A Gewirthian Conception of the Right to Enabled Suicide in England and Wales

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Contents

Abstract

This thesis seeks to answer a seemingly intractable question in English human rights law: how should we understand the nature, constituent elements and application of a human right to enabled suicide? A moral framework is developed, based on the theories of Alan Gewirth and Deryck Beyleveld, in order to critique the approach to such a right in English law. The thesis argues that current approaches have failed to articulate the status of this right fully, in particular as regards the balance between its exercise and the protection of the right to life of others. Thus, the thesis seeks to use Gewirthian theory to defend an alternative understanding of the human right to enabled suicide. This ethically justified right is used to resolve the intractable questions of human rights law that, it is argued, have undermined the legal response to the right to enabled suicide thus far. Specifically, the thesis will address the problem of a slippery slope resulting from possible abuse of procedures designed to give effect to the right. The thesis will also consider the defensibility of apparent inconsistency between English laws prohibiting assisted suicide and laws regulating different courses of 'suicidal' conduct such as refusal of vital treatments and 'life-shortening' treatment. The thesis will not claim that there is one ideal form of human rights-compliant legal response to these questions, but it will seek to justify certain minimal requirements of a Gewirthian conception of a human right to enabled suicide. The original and significant contribution of this thesis to knowledge is therefore the development of a detailed framework to govern the balance between the right to enabled suicide and the countervailing right to life, and the application of this framework to English law on assisted suicide and voluntary euthanasia.

Chapter 1: Introduction to thesis and the four hypothetical human rights-claims for enabled suicide

1.1 Introduction

The late Lord Bingham in the UK House of Lords in *R(Pretty) v DPP*[1] began his judgment thus:

> The questions whether the terminally ill, or others, should be free to seek assistance in taking their own lives, and if so in what circumstances and subject to what safeguards, are of great social, ethical and religious significance and are questions on which widely differing beliefs and view are held, often strongly.

This thesis seeks to navigate these complex issues of morality and law to determine how the UK should respond to the challenge of protecting human autonomy at the end of our lives. The focus of the thesis is on a human rights-based analysis and evaluation of the current law regulating when, if at all, a person is permitted to assist in another's suicide, or kill him at his request. The foundation of the human rights-based analysis is an ethically rationalist conception[2] of the requirements of relevant human rights in the European Convention on Human Rights (ECHR).[3]

This chapter will provide an outline of the subjects considered in the thesis (1.1) and will set out four hypothetical human rights claims which provide the foundation for the analysis and evaluation in this thesis (1.3.3). This introductory chapter includes an overview of: the legal area (1.2.1); practical significance of the topic (1.2.2); academic analysis (1.2.3); and various definitions of voluntary lethal conduct (1.2.4). The particular approach adopted in this thesis

[1] *R (Pretty) v DPP* [2001] UKHL 61 [2]. The seminal case considering the merits of the claim by Diane Pretty that the DPP should offer an assurance that her husband would not be subject to criminal investigation and potentially severe criminal sanctions on the basis of her human right to enabled suicide (see 6.5).
[2] See definition in 1.2.4.
[3] See 4.2. As 4.2 explains, the thesis does not seek to justify its moral approach from first principles but relies on the assumption that human rights are morally valid, so it does not seek to put forward an ethically rationalist conception of rights regardless of the ECHR requirements (Beyleveld 2011).

is set out in 1.3, including an overview of the research questions (1.3.1), the research methodology adopted (1.3.2) and discussion of the original claims made (1.3.4). Finally the structure of the thesis and the detailed structure of the chapters is set out in 1.4.

1.2 Outline of research area

1.2.1 Overview of research area

Human rights-based analysis and evaluation has been broadly criticised from a range of perspectives (eg Dembour 2006), especially for absolutism and for being overly individualistic (eg Kass 1993; Sandel 1982, 48). These criticisms find that modern applications of human rights to sensitive areas of bioethics go beyond their justificatory basis, and that modern applications of human rights to, in particular, abortion or suicide are invalid (Cornides 2008). In particular, criticisms applied as regards assisted suicide and requested killing find that human rights requirements must be to protect the *lives* of humans (Keown 2002, 5; see also Wicks 2010, 22*ff.*).

These criticisms have prompted a variety of responses from advocates of human rights-based reform in this area; the responses are characterised by different strategies of justification for the degrees of restriction for assisted suicide and requested killing in practice, while defending the foundational commitment to autonomy associated with human rights (eg Dworkin 1993, 11*ff.*). The most significant divide between these responses is based upon the nature of a human 'right' as a theoretical and practical requirement relevant to individuals and social institutions (Raz 1984). This apparently abstract aspect of rights theory has direct significance for a human right to assisted suicide or requested killing, since on a will-based approach (Hart 1984) the human right to choose how and when to die is implied by the protection of the 'right to life' and on the other, opposed, interest-based approach (MacCormick 1977) that is not the case (see further 2.2.4).

English law on assisted suicide and voluntary euthanasia is in flux. It retains a facial adherence to the principle that life must be preserved where possible as intrinsically valuable

or ‘sacred’ and on this basis proscribes involvement of others in requested killing or assisted suicide (eg Keown 2002, 20*ff.*; *Airedale NHS Respondents v Bland*;[4] s2 Suicide Act 1961). However, the true nature of the legal position has been deeply contested by theorists and commentators for decades, the prevalent argument being that preservation of unwanted life is *not* a principle of English regulation in modern times; the ‘exception’ for suicide and instances where continued life would have involved unbearable suffering are relied on to support their proposition (eg Williams 1974). Exceptions were (and still are) created *de facto* by prevalent non-prosecution and non-conviction of compassionate ‘mercy’ killers who participate in requested killing, as well as non-prosecution of compassionate assistance in suicide (Jonsen Veatch and Walters 1998, 113*ff.*). This characterisation of English law as containing exceptions to the prohibition of murder on request or assisted suicide is criticised as a misunderstanding of the legal sanctity of life doctrine (eg Keown 2002, 7*ff.*). Those adopting a sanctity of life position also argue that, in practice, abandoning the principle as a foundation of English law by straightforwardly permitting assisted suicide would in practice lead to unwanted *killing* (eg Keown 2002, 72*ff.*; see further chapter 9).

More recently, especially in the last decade, there have been more mixed official responses to regulating requested killing and assisted suicide, driven by various developments (see chapters 6-9). The UK’s mixed response is reflected in the policies of similar Western democracies. Among the most important of these is the emergence of officially recognised assisted suicide and requested killing in the Netherlands, and in Oregon (America) as well as the expansion of assisted suicide in Switzerland. The social forces behind such developments are commonly understood to be the efficacy of modern health-care in preserving patients’ lives, which is not matched by a similar ability to preserve patients’ quality of life (see eg Chapple et al 2005; Angell 2004). Further reasons are cited as related to the increasingly elderly population, with a greater incidence of patients suffering from severe chronic diseases and advancing to the final stages of such diseases, placing a strain on healthcare provision in attempting to meet patients’ needs beyond the basic preservation of life (eg Gauthier et al 2013; Commission on Assisted Dying 2011, 158*f.*).[5] Finally, trends in healthcare generally

[4] *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 858.
[5] See also the Select Committee on Public Service and Demographic Change 2013.

favour enhanced patient control over medical treatment, and in society generally there is an increased expectation of a high quality of life (eg Tauber 2005, 57*ff*.).

A more developed policy of non-prosecution by successive Directors of Public Prosecutions forms one aspect of modern developments in the regulation of assisted suicide and requested killing in England (see further 6.5). Significant developments in English law have also occurred as regards the refusal of vital treatment, especially the phenomenon of advanced refusal of vital treatment. Advanced refusal in particular is considered to be close to an exception to the proscription on ending unwanted life (Huxtable 2007, 72-73). The phenomena are viewed as proximate to such an exception since such advanced refusals require an individual to specify circumstances in which (since he will not be conscious or have capacity to resist treatment at the time) others who would normally be under a duty to preserve his life will abstain from doing so, resulting in his death (eg Samanta and Samanta 2013, 691).

Reform of English law and regulation of this issue is directed towards the perceived inadequacy of the current legal framework in guiding, overseeing and protecting autonomous choice as regards the circumstances and manner of wanted death (eg Commission on Assisted Dying 2011, 297*f*.). Perceived problems are not restricted to the apparent prohibition of assistance with suicide, or of killing on request, but also to vagaries in official regulation. The perception that official regulation is unprincipled and confused provides the foundation for criticisms that the regulation is ultimately counterproductive to safeguarding life. Critics point to cases encouraging earlier suicide and undermining the support given to vulnerable suicidal individuals (eg Commission on Assisted Dying 2011, 296*f*.). These criticisms are recognised as engaging with the protection of the right to life within human rights theory and practice (eg Griffin 2008, 216*ff*). UK law has been the subject of human rights-based criticism from various official sources, including domestic courts,[6] courts of international law,[7] and Parliamentary committees with a view to legislation (eg Select Committee on the Assisted Dying for the Terminally Ill Bill 2005).[8]

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[6] See eg *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200.
[7] See eg *Pretty v UK* (2002) 35 EHRR 1.
[8] See 9.5.

Legislative reforms in England and Wales are currently focused upon assisted suicide (eg the Assisted Dying Bill 2014-15). Reform of requested killing has been viewed as too controversial, and too difficult to police effectively, for it to be adopted as part of a platform for official reform. The reluctance to accept requested killing is matched in most Western democracies, despite certain exceptions in Europe and the United States. Official proposals of reforms for assisted suicide have built on reforms abroad that are perceived as particularly successful (Commission on Assisted Dying 2011, 315*ff*.). Proposals for reform of assisted suicide have been accompanied by support for palliative and medical services so that treatment enhancing quality of life is made sufficiently available (eg Commission on Assisted Dying 2011, 297*f*.). Reform proposals have been met, predictably, with criticism from adherents of the principle that English law in this area should be based primarily on the preservation of life (eg Keown 2012, 94*f*.). These criticisms centre on the undermining of support for the preservation of the lives of vulnerable people, especially those near the end of their lives, leading to unwanted killing. A recurring criticism is that the purported safeguards designed to prevent unwanted killing would be insufficiently effective in practice, citing evidence from existing regimes that permit assisted suicide (eg Keown 2002, 72*ff*; Gorsuch 2006, 157*ff*.). This criticism, known as the 'slippery slope' argument, finds that permitting assisted suicide on one basis will lead to regulation providing for expanded permissions for assisted suicide on further bases, and ultimately will lead to killing on request (eg Huxtable 2007, 146*f*.; Twycross 1997, 160-61; Keown 2002, 72*ff*). The end of the 'slippery slope' is argued at the extreme to be the sanctioning of the unwanted killing of the vulnerable in a way redolent of State-sanctioned euthanasia in certain, infamous, totalitarian regimes (Finnis 1997, 23-24) or, less radically but still extremely seriously, to the diversion of societies' resources away from the care of vulnerable people at the end of life (eg Keown 2012, 94*f*).

1.2.2 Practical importance of thesis

This thesis seeks to engage with the above-described legal reforms and to advance an original rights-based analysis that is capable of meeting the arguments of those who oppose legalisation, as well as identify potential problems with the current direction of legal reform.

In general, the terminology used by those seeking to reform the English law prohibiting assisted suicide or murder[9] does not refer to 'suicide' but rather cites rights 'at the end of life' and the right to an 'assisted death'. The Commission on Assisted Dying (2011, 305) sets out its position on reform of English law as follows:

> The Commission recommends that any new assisted dying legislation should include measures to extend the right to request an assisted death only to people who are terminally ill. Those with significant physical impairments would therefore only be eligible if they had a coexisting terminal illness.

These proposals have resulted in the Assisted Dying Bill 2014-15, which is currently in the committee stage (1st sitting on 7th November 2014,[10] 2nd sitting on 16th January). However, the terminology of 'assisted death' has been attacked as a 'fudge'. Keown observes (2012, 83):

> When the euphemisms of 'doctor assisted death' and 'assisted dying' are stripped away, this is the stark question at the heart of the euthanasia debate. The debate is not about whether doctors should be allowed to 'help people die'. That is what good doctors do, and have always done by their skilful use of palliative medicine…The euthanasia debate is not about killing pain; it is about killing patients.

This 'stark' question of the suicidal nature of the intention to die when and how one chooses with the assistance of another is at the heart of the idea of the right to 'assisted death' (eg oral evidence of Tony Nicklinson cited by the Commission on Assisted Dying 2011, 99). The relevance of voluntariness as to the choice to undergo enabled suicide was recognised by the House of Lords in *R(Purdy) v DPP*,[11] per Lord Phillips:

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[9] It should be noted that English law has certain very narrow exceptions to enabled suicide (see chapters 7-8).
[10] HL Deb Vol 756 Col 1852, 7th November 2014. See 9.5.
[11] [2009] UKHL 45 (HL).

> Respect for a person's 'private life', which is the only part of article 8(1) which is in play here, relates to the way a person lives. The way she chooses to pass the closing moments of her life is part of the act of living, and she has the right to ask that this too must be respected. In that respect Mrs Pretty has a right of self-determination. In that sense, her private life is engaged even where in the face of a terminal illness she chooses death rather than life. [12]

This was also the basis of the claims raised before the Supreme Court in the recent *Nicklinson*[13] litigation.

This thesis seeks to analyse and evaluate the right to choose how and when to die using the clear term enabled *suicide* to emphasise the focal concern with control that is inherent in rights in general, and the issues of consent, information, freedom and *identity* that occur when others become involved in suicide. The following conversation between a woman, Mary, who sought assistance in her suicide from her family in order to avoid experiencing the final stages of secondary cancer is illustrative of these issues (the conversation occurs between her son, Steve, and her step-daughter, Ann, shortly before they assisted in Mary's suicide by providing sleeping pills (Shavelson 1995, 196-97):

> [Mary's step-daughter Anne] "Mary, we, your family, me, you... we have to understand this. Slow down a bit. Put on your oxygen, and I will leave you alone with the family for a while. That's not asking much. When I return, we'll talk about your suicide…"
> 45 minutes later, [Anne] returned to Mary's room. [Mary's son Steve] was the first to speak. "We agree," he said simply.
>
> [Ann] "You mean you'll support her decision?"
>
> [Steve] "No…months ago, or yesterday, we would have supported her right to make this decision. But we wouldn't have agreed with it. Now, we agree.

[12] *Ibid* [36]; Lord Phillips cited his finding in *R(Pretty) v DPP* [2001] UKHL 61 (HL) [100] although he noted in *Purdy* that he did not dissent from the finding on Art 8(1) in *Pretty*.
[13] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [55].

> Tonight, seeing the way things are, I not only support mother's decision, I understand why she's making it…"

The above decision to undergo enabled suicide was, of course, 'consensual' although describing the decision in such terms might appear strange, since it is more the case that Mary was directing, even pleading, with her family to assist. In such a situation the term 'consent' fails to capture Mary's attitude towards her suicide fully. Her attitude is obviously based on the accuracy of the information available to her - the terminal diagnosis. This information includes the fact that she had clearly entered the final stages of terminal cancer (a fact established to a high degree of scientific certainty in Mary's case). Mary's mental state is also crucial; it was clear to her family that Mary was not 'merely' depressed or making a 'cry for help'. Finally, the circumstance of support for her decision-making was crucial; Mary arrived at the decision with the support of her sister-in-law, and was not in any sense abandoned to her fate by her family or otherwise disempowered or passive as regards her decision; rather, she took control and advanced her suicidal purpose against her family's initial doubts and in the face of a legal prohibition that would have exposed her family to criminal prosecution had they been discovered. Mary's desire to die is an autonomous choice that she identifies with since it relates to herself.

This thesis supports reform to implement the right to enabled suicide in English law in a way that protects and empowers people seeking suicide on the basis that these are matters of acute personal, social, ethical and legal importance. Chapter 5 will set out the way in which a right to choose how and when to die in a situation such as Mary's could be realised. Chapter 9 evaluates reforms which would recognise such a right in English law.

1.2.3 Literature review

There is an extensive range of literature on this topic, so all that is attempted here is a short survey of the research most relevant to the particular focus of this thesis (set out below at 1.3). The focus of this short literature review is therefore on the moral theory relevant to human rights, to legal and human rights-based analysis and evaluation of assisted suicide and requested killing.

There are various works that set out different moral positions from which the authors evaluate regulation of assisted suicide and requested killing; prominent examples of such works include: utilitarian theory (eg Glover 1977; Harris 1985; Singer 1993); rights-based theory (eg Brock 1993; Dworkin 1993; Beyleveld and Brownsword 2001; 2007); duty-based theory (eg Keown 2001; 2012; Smith 2006; Patterson 2008). There are also accounts that seek to create a compromise between prominent moral positions (eg Huxtable 2007; 2013).

Works considering the regulation of assisted suicide and requested killing adopt differing foci for their legal analysis; prominent examples of such works include: socio-legal perspectives (eg Woods 2006); institutional regulatory (eg Perring 2013; Twycross 1995); comparative legal (Griffiths, Weyers and Adams 2008; Battin 2005); 'black letter' legal (eg Williams 1974; Keown 2002; Munby 2013), as well as rights-based legal perspectives (eg Lewis 2007). Works from within the latter perspective adopt various methodologies; prominent examples of such works include: rights-based moral analysis and evaluation (eg Dworkin 1993); rights-based ethical/legal compromise (eg Lewis 2007), and legal analysis of human rights principles deriving from court decisions (eg Cotè 2012).

1.2.4 Definitions

The terminology of 'assisted suicide' and 'requested killing' used above (1.2.1) is inexact and the term 'enabled suicide' used to describe both actions is preferred in this thesis. This term – explained below – is not generally used in analysis of this topic, but it is argued that it is beneficial to understanding since the term conveys fewer underlying assumptions than the commonly used terms, such as 'euthanasia' or 'assisted suicide'. There is an uncommon usage of the term 'enabled suicide' to mean minimal yet decisive aid in suicide (eg Prado 2000, 48), but that is not the meaning adopted in this thesis.

The characterisation of all requested involvement in another's wanted death as 'enabled suicide' is a rejection of the distinction between different forms of killing or suicidal conduct where death is wanted, and an affirmation of the central importance of voluntary choice of the suicidal individual (see further the hypothetical claims to enabled suicide in 1.3.3). This rejection of the decisive significance of such distinctions reflects the Gewirthian rights-based moral theory preferred in this thesis (see further 1.3.1, 2.6). The term 'enabling' is preferred

in the thesis as distinct from ‘assistance’ because the latter term is generally, although inaccurately, accepted in the literature (arguably a political use of language) as implying a significant degree of aid, but falling short of performing the killing action. ‘Enabling’ has a broader definition than assistance (Oxford English Dictionary 2014): ‘to give (someone) the… means to do something; make it possible for [the end to be achieved]’. Thus, ‘enabling’ could cover performing the killing action, as well as covering lesser forms of aid, in the case of an individual incapable of committing suicide by his own action.

The relationship between ‘enabled suicide’ and terms prevalent in the literature but not used in this thesis:

- *Requested killing* refers to enabled suicide since it denotes the performance of the killing act.
- *Assisted suicide* refers to (typically a high degree of) involvement in another’s suicide without performing the final killing act. Enabled suicide encompasses assisted suicide.
- *Euthanasia* is a morally loaded term, meaning literally a ‘good death’, which is in practice used to refer to actions that include the otherwise impermissible killing of another (rather than assistance), but which are viewed as justifiable or excused due to the situation of the person concerned. Enabling a suicide by performing the killing act is a form of euthanasia if the action of enabling suicide is deemed to be justified.
- *Voluntary active euthanasia* refers to a type of euthanasia in which the person concerned expresses a suicidal purpose and another person performs the killing act on his request. The distinction between action and inaction is viewed as significant as a principle of law (see eg 8.2) and in certain moral theories (especially deontological moral theory; see further 2.4-2.5); voluntary *passive* euthanasia refers to justified non-interference in a suicidal purpose. Voluntary active euthanasia denotes enabling suicide by performing the killing act where the enabled suicide is justifiable. In this thesis the term ‘enabled suicide’ is not used to refer to involuntary active euthanasia (the killing of a person who has not expressed and/or cannot express a choice to die, such as someone in a permanent vegetative state where no advance directive is available covering the situation (see 8.2.2)).

The '*right to enabled suicide'* that is referred to in this section refers to a general idea of a human 'right' to enabled suicide which is used for convenience. The thesis will ultimately suggest a right to enabled suicide as a generic right of agency (see 2.6 and chapter 4) but alternative approaches to such a right are considered first.

The moral right to enabled suicide is used in the thesis to refer to a moral claim understood from a Gewirthian position. The thesis adopts an ethically rationalist conception of morality in relation to its proposals to impose categorically binding standards for action (see 2.3, 2.6 and 4.2). The ethically rationalist conception of morality in this thesis is in the Kantian tradition (in particular Kant's *Groundwork to the Metaphysics of Morals* 1785)[14] advanced by Alan Gewirth in *Reason and Morality* (1978), by Deryck Beyleveld in *The Dialectical Necessity of Morality* (1991) and in the latter's article in *Human Rights Review* 'The Principle of Generic Consistency as the Supreme Principle of Human Rights' (2011). The conception of morality relevant to this thesis is discussed further in chapters 2 and 4.

In an attempt to avoid vagaries of language that might confuse the argument this thesis adopts the following linguistic conventions:

- 'UK' / 'England and Wales' / 'English law'
    - The thesis only refers to law, practice and potential reforms in England and Wales. However, the term the 'UK' or the 'State' will be used to refer to England and Wales.
    - 'England and Wales' is preferred to 'England' when referring to the Kingdom within the UK to which the relevant laws (of murder and assisted suicide) are applicable (Scots law and the law of Northern Ireland post-partition are not referred to regardless of the territorial applicability of the law in question).
    - 'English law' or the 'English legal system' are preferred to 'UK law' in order to distinguish from Scots law and the law of Northern Ireland post-partition.
- *'Law'*
    - The term 'law' will be used when discussing 'statute law' or 'case-law' but the use of the term should not necessarily be taken to imply that the law in

[14] The translation referred to is *The Moral Law* by Paton (1948).

question is ‘morally legitimate power’ (see Beyleveld and Brownsword 1991: 159). The word ‘law’ is used to describe ‘positive law’, thereby encompassing some instances of morally illegitimate power and also excluding quasi-legal rules or soft law, such as the DPP Guidelines (2010).

- ‘Official’
    - In this thesis the term ‘official’ refers to an individual who is legally authorised/required to perform a function. Typically, the thesis refers to officials who are authorised/required to assess the competence of suicidal individuals or to interfere with actions that enable suicidal individuals to achieve their purposes.
- ‘Competence’ / ‘Competent suicide’
    - Competence refers to the ability to understand a chosen purpose; an individual’s competence divides between his general, or ‘dispositional,’ ability to understand his decision (cognitive ability) and his ability to apply his dispositional ability at a specific point in order to make his decision (occurent ability). An individual’s competence to commit suicide is therefore his ability to act with sufficient (dispositional/occurent) ability to understand his suicidal choice.
- ‘Agent’ / (‘he’)
    - The term ‘agent’ is typically used to refer to a being that appears to have the ability to pursue chosen purposes and exercises agent rights (eg Gewirth 1978, 26-27; Pattinson 2002a, 3; see also 2.6 and chapters 4). At various points it is necessary to distinguish between an agent (i.e. a being who has the ability to pursue chosen purposes) and an ostensible agent (i.e. a being who appears to have the ability to pursue chosen purposes; Beyleveld and Pattinson 2000).
    - The term ‘he’ is used as the relevant pronoun for the subject ‘agent’ because the English language lacks a gender-neutral singular pronoun (a comparative pronoun in spoken standard Mandarin is the gender neutral *tā* 他 which conveys no gender distinction). The difficulty with ‘it’ is that such a term usually denotes non-agency (eg a chair is an ‘it’ while Simon is a ‘he’), and therefore creates confusion in sentences referring to agents in transactional relationships relevant to enabled suicide. ‘She’ would have been equally acceptable.

- ‘Suicidal potentially incompetent agent’ (‘suicidal PIA’)
    - A being who appears to have the ability to pursue chosen purposes and exercises agent rights but who might not have the (dispositional/occurent) ability to understand his suicidal purpose (see chapter 5) and therefore he might be unable to exercise his agent right to enabled suicide.

1.3 Approach to research area in this thesis

1.3.1 Research focus

This thesis seeks to defend one interpretation of the foundational moral commitment to the protection of human rights listed in the ECHR in order to justify the existence and nature of a Convention right to enabled suicide.[15] This justified right will then be referred to in order to evaluate English law and regulation of enabled suicide for compliance with such a right. The thesis argues that the ECtHR’s findings in *Pretty v UK*[16] and *Haas v Switzerland*[17] can be characterised as recognising such a right under Article 8, but that the Court has failed to articulate fully the status of this right within the Convention framework, and in particular has not fully addressed its relation with the right to life (chapter 3). Thus the thesis seeks to use ethical theory to justify the development of a fully articulated right to enabled suicide based on the concept of human rights in the ECHR. Chapter 9 then discusses the proper direction for legal reform to take to give practical effect to the right. The purpose of using ethical theory within this thesis is to make a contribution of practical significance which could inform judicial reasoning and the legislative process in this context in relation to an interpretation of human rights law.

There are clearly various different conceptions of human rights and theorists are divided between different approaches to the basis of human rights (Griffin 2008, 14*ff.*; Gilabert 2011). The possibility of an authoritative basis for human rights requires defence (Gewirth

[15] As chapters 2-4 explains, by a ‘right to enabled suicide’ is meant a human right justified under the moral framework put forward in the thesis, not that domestic law or the ECtHR has recognised such a right.
[16] (2002) 35 EHRR 1.
[17] (2011) 53 EHRR 33.

1981, 4-6).[18] Furthermore, there are competing conceptions of the function of rights which alter the nature of a human right to enabled suicide. This thesis will seek to justify a preference for the will-theory of rights (eg Hart 1982). It is from this position that this thesis proposes to assess the correct balance between the resulting duty placed on the State to permit the exercise of the right to enabled suicide and to restrict such exercise in accordance with the countervailing duty to safeguard the lives of 'vulnerable' people.

The ethical theory advanced in this thesis as the basis of the human right to enabled suicide is rights-based, and thus finds that self-governance and free action is central to moral permissibility (see further 2.6). The particular rights-based ethical stance adopted is that of Alan Gewirth, which finds that the supreme principle of morality is based on agency (Gewirth 1978, 21*ff*.). A Gewirthian rights-based ethical position is committed to non-interference and assistance with self-regarding choices, accepting limits on an agent's free action only where his action impinges on the agency of others (Gewirth 1978, 21*ff*.). This rights-based position is therefore in principle committed to defending suicidal choices unless it can be shown that suicide impinges upon others sufficiently to render such an action impermissible (eg Beyleveld and Brownsword 2001, 190, 236*ff*.). However, it is possible that a legal prohibition of assistance for apparent suicides could be justified if it resulted in practice in protecting vulnerable or ill-informed individuals from the risk of unwanted killing or pressured suicide.

The essence of the application of the right to enabled suicide in this thesis concerns the correct balance to be struck between the right to enabled suicide and the conflicting duty to safeguard life. The justifiability of any restrictions upon the exercise of such a right is crucial. The UK government is, of course, entitled to protect human rights by putting in place procedures that reduce the possibility of unwanted killing or pressured suicide. If the government is unable to regulate the exercise of the right to enabled suicide without risking the life of others then this failure could justify an absolute prohibition. In order for the government to secure the right to enabled suicide responsibly in English law, it must establish

[18] It is a widely held view among legal theorists that principles of interpretation of ECHR rights should not be held to abstract theoretical standards, but to conventional sources in the text of the Treaty and in statements of the ECtHR (eg Gearty 2004).

whether those who accede to requests for euthanasia or assisted suicide are doing so in a way that is sufficiently informed and voluntary. The government's responsibility to secure the right of persons to enabled suicide in practice cannot realistically amount to more than a *minimal* relaxation on current restrictions, since English law cannot achieve safe, dignified, enabled suicide for all within its jurisdiction. The government's compliance with its responsibility requires that a realistic assessment of the capacity of relevant officials is made to exclude risks of abuse and deficiencies of procedure sufficiently. In this regard the thesis will take account of the problematic nature of acute challenges, especially as regards evaluating the competence of those with the greatest reason to contemplate suicide seriously, such as Mary.

1.3.2 Research methodology

Information has been gathered from both primary and secondary sources relating to domestic and international law and practice, together with academic argument in relation to these sources and to ethical theory. The analysis and evaluation of these sources is from the perspective of the human rights of various hypothetical applicants, whose situations are set out in the next sub-section (1.3.3). In order to defend a practically reasonable and effective argument for the realisation of these rights, this thesis will seek to defend a supreme principle of human rights from which it might be determined whether such applicants possess the right claimed and the way it should be realised in English law (chapter 4). To establish the need for and the plausibility of such a supreme principle the thesis will initially consider various moral judgements concerning human rights and enabled suicide, and will go on to examine the approach taken by the European Court of Human Rights. The supreme principle is based on Gewirthian rights-based moral theory which is related to Kantian transcendentalism, but is distinct in significant respects, which to detail in full would require development beyond the boundaries of this introductory section (see further 4.2-4.3). It is sufficient for this section to state that the Gewirthian theory applied in this thesis is that developed by Beyleveld (2011) and does not rely on a demonstration of the validity of human rights from non-moral premises.

1.3.3 Hypothetical rights-claims tested in this thesis

The claims that will be tested are four hypothetical situations in which an adult suicidal claimant (**S**) makes a specific type of request of an enabler (**E**) and asks any official empowered to interfere (**O**) not to interfere with the fulfilment of the request. These situations include requests for voluntary euthanasia ("take my life") and requests for assisted suicide ("help me die"). There are two further requests that are forms of voluntary euthanasia and assisted suicide. The phenomenon of 'voluntary lethal treatment,' a form of voluntary euthanasia, is captured by the request for enabled suicide in the "end my suffering" claim. The phenomenon of refusal of vital treatment is captured by the "let me die" claim. These claims will form the basis for the thesis's central argument that giving effect to the right to enabled suicide requires a facilitative regulatory framework in which E may lawfully act on S's request, subject only to such interference from O as is reasonably necessary to determining that this is a sufficiently free and informed request. Thus, it is anticipated that the right to enabled suicide will not fully comply with what S wants, since O may still interfere if he cannot distinguish between S's request and possible insufficiently free and informed requests for enabled suicide of others.

In each situation the suicidal claimant is **S**; the person enabling him is **E** and the official who could interfere is **O**.

"Take my life"

S wants to end his life but cannot due to being physically incapable of doing so. He claims that **O** should not interfere when **E** kills him on his request.

"Help me die"

S wishes to die but is unable to do so in the way he chooses. He claims that **O** should not interfere when **E** provides the requisite assistance with his suicide.

"End my suffering"

S is in severe pain which he considers that he should no longer have to tolerate. **S** claims that **O** should not interfere when **E** ends his pain, even if so doing results in ending **S**'s life, a consequence which **S** accepts.

"Let me die"

S requires vital healthcare if he is to survive but he does not wish to receive it (or continue to receive it) because he desires to die. He claims that O should not interfere when E does not provide (or discontinues the provision of) vital healthcare to him.

1.3.4 Claim to originality

This thesis is the first full-length treatment of a Gewirthian rights-based approach to the right to enabled suicide. The thesis advances an original defence of an expansive individualistic approach to autonomy in the context of human rights and enabled suicide. In doing so the thesis reaches beyond existing Gewirthian analysis of this subject by providing a sustained analysis on the topic, as opposed to addressing it as part of a wider legal analysis (for example, in Beyleveld and Brownsword 2007, 276*ff.*).[19] The thesis also provides a sustained ethical and legal analysis of emergent legal material, particularly the Assisted Dying Bill 2014-15 (9.5) including the committee stage proposals (first sitting on 7th November 2014)[20] and the seminal *Nicklinson*[21] case (published on 25th June 2014) (see primarily 6.4-6.7, but see also chapters 6-9 generally) which has not so far been conducted.

1.3.5 Research Questions

Has the European Court of Human Rights articulated a principled framework of human rights that is capable of addressing the apparently conflicting fundamental commitment to preserving life and protecting autonomy that is represented by a Convention right to enabled suicide? Can an alternative, more defensible, basis for interpretation of a Convention right to enabled suicide be established, and how can such a basis justify one interpretation of the content of such a right? This question is primarily addressed in chapters 2-4 (see below 1.4).

[19] See further in this thesis: chapter 5.
[20] HL Deb Vol 756 Col 1852, 7th November 2014. See 9.5.
[21] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200.

How can the UK ensure that giving effect to the purported human right to enabled suicide would not unacceptably increase the risk of incompetent people being killed or being pressured into suicide? This question is primarily addressed in chapter 5, and is also addressed in 4.5.

Is the prohibition on assisted suicide and killing on request a proportionate restriction on the claimants' rights in the "take my life" and "help me die" situations? This question is addressed primarily in chapter 6.

Is there an exception to the prohibition on killing on request that applies in the "end my suffering" situation? Is there an exception to the English legal prohibition on assisted suicide in the "let me die" situation? If there are such exceptions, are the limitations imposed on the exercise of the right to enabled suicide in those situations proportionate? These questions are addressed primarily in chapters 7 and 8.

What level of legally sanctioned interference with enabling actions would be proportionate in a legislative scheme designed to minimise the risks to the right to life of others to an acceptable degree? Do current proposals for legislative reform go far enough? How might future reforms create greater compliance with the right to enabled suicide? These questions are addressed primarily in chapters 9 and 10.

1.4 Structure of thesis

Chapter 2 stipulates a Hohfeldian concept of a moral human claim-right to enabled suicide and sets out competing conceptions of the moral basis of such a right. The chapter delineates a possible Gewirthian moral right to enabled suicide, and defends it from basic objections.

Chapter 3 describes the Convention right to enabled suicide in terms of a Hohfeldian claim-right. The chapter will set out the preliminary subject, basis and respondent of such a right as granted by the ECHR text as interpreted by the European Court of Human Rights (ECtHR). The chapter will go on to consider the specific findings of the ECtHR bearing on the interest and nature of such a right and consider its findings bearing on the UK's responsibility to secure it. The chapter will argue that these findings are not incompatible with the recognition

of a Gewirthian right to enabled suicide under the ECHR which will be defended in chapter 4.

Chapter 4 defends the rights-based moral theory of Alan Gewirth as a foundation for the Convention right to enabled suicide. An outline of the content of the human right to enabled suicide is derived from this foundation.

Chapter 5 sets out a proposed basis for proportionate legal restrictions on the right to enabled suicide. Chapters 4 and 5 therefore provide the justificatory basis for evaluating the current near-absolute prohibition on enabled suicide in English law considered in chapters 6-8 and current proposals for reform in chapter 9. This evaluation is concluded in chapter 10.

Chapter 6 relies on the right to enabled suicide of the hypothetical claimant in the "take my life" and "help me die" situations in order to critique current English law relating to those situations.

Chapter 7 relies on the right to enabled suicide of the hypothetical claimant in the "end my suffering" situation in order to critique current English law relating to that situation.

Chapter 8 relies on the right to enabled suicide of the hypothetical claimant in the "let me die" situation in order to critique current English law relating to that situation.

Chapter 9 relies on the right to enabled suicide in order to critique current proposed legislative reform designed to permit assisted suicide in England and Wales.

Chapter 10 comes to a final conclusion on the proportionality of English law and proposes a Gewirthian approach to legislative reform to permit the right to enabled suicide.

Chapter 2: Outlining approaches of human rights theorists to the concept of a right to enabled suicide

2.1 Introduction

The different claims to enabled suicide described in the last chapter (i.e. “take my life”, “help me to die”, “end my suffering” and “let me die”) divide human rights theorists. Enabling suicide is defended by some academics as an exercise of self-determination which, they argue, is a concept that is foundational to human rights (Griffin 2008, 219*ff.*). A diametrically opposed approach is taken by academics who argue that self-determination should be understood by reference to a foundational human right to protect one’s wellbeing which, they argue, would be undermined by permitting enabled suicide (eg Keown 2002, 40*ff.*). The existence of fundamental disagreement as to the justification for the existence and nature of the human right to enabled suicide illustrates the need for particular clarity as to the justificatory approach adopted in a thesis of this nature. These diverse approaches cannot be fully explored in a thesis focussed on resolving the moral issues implicit in defending the introduction of such a right into English law. This chapter will stipulate a definition of a human right to enabled suicide in Hohfeldian terms and seek to outline Gewirthian rights-based moral theory to defend it. The following chapter will evaluate the extent to which a Gewirthian right to enabled suicide is recognised under the ECHR, and chapter 4 will set out a full moral defence for interpreting the ECHR compatibly with such a right.

This chapter will firstly outline and argue for an understanding of the human right to enabled suicide as a Hohfeldian claim-right held by human persons against others (2.2). The constituent elements of such a right are set out and related to the hypothetical claims (“take my life” etc in 1.3.3). The crucial preliminary question of the status of a *claim* to such a rights-requirement is addressed. The chapter will then turn to the justificatory basis, in terms of moral theory, for such a right (2.3). It will address the arguments for the duty-based sanctity of life view that recognition of a human right to enabled suicide undermines the value of life (2.4). These arguments will be challenged in terms of their rational consistency in distinguishing between some “end my suffering” and “let me die” claims. The chapter will then set out the alternative moral bases for human rights that reject the sanctity of life view. The moral positions considered are the rule-utilitarian ‘quality of life’ view and the rights-

based view that agency should be inviolate (2.5). Both rule-utilitarian and rights-based moral theories are developed to provide an outline defence of these conceptions. The chapter ends by outlining Gewirthian theory (developed in chapter 4) and defending it from basic objections (2.6).

2.2 The concept of a human right to enabled suicide

2.2.1 Introduction

To claim that a human 'right' to enabled suicide exists is, at its most basic, a claim that there is a requirement that enabled suicide should be permitted generally or in certain circumstances. To define this purported requirement in terms of the hypothetical claims to "take my life," "help me die," "end my suffering" and "let me die" it is necessary to address the preliminary question of who is being required to do what as regards the enabler's (E's) conduct in enabling the suicidal claimant (S).[1] Human rights, such as those recognised under the ECHR, are conventionally accepted as imposing requirements upon States and thus upon State institutions, officials and functions, including the creation and application of laws (eg Letsas 2007, 18-21; Griffin 2008, 191*ff.*). On this view it would appear that only the State has a duty to the person requesting suicide (S) as regards his claim to a human right to enabled suicide. However, this conventional acceptance could reasonably be interpreted as indicating either that the respondent to a 'human rights-requirement' is the State or State-entity, or alternatively that the respondents are other individuals and the State *enforces* the duty in question (eg Beyleveld and Pattinson 2002). Reliance on this distinction is not central to the characterisation of the State's responsibility in relation to a right to enabled suicide in this thesis, but it is a significant preliminary point and central to a Gewirthian interpretation of human rights.

It is also necessary to elaborate on and defend the premise of a 'human rights-requirement' as relating to individual conduct. While a *rights*-requirement does, by definition, refer to individual conduct (eg Gewirth 1982, 2) it is necessary to defend this premise. It is

[1] See claims in 1.3.3.

conventionally accepted that a human right, as a rights-requirement, refers to the permissibility of individual conduct. However, the plausibility of *human* 'rights' as having a similar conceptual structure to individual (eg moral/legal) rights is denied by theorists who adopt a public-oriented conduct model of human 'rights' under which it is *public* conduct that is the object of the purported requirement.[2] If that is the case then nobody would bear the suicidal claimant (S) a duty directly due to his claimed human right to enabled suicide. This thesis rejects such a conception of the duty.

2.2.2 The concept of a Hohfeldian human right to enabled suicide and key objections

There are various approaches to the analysis of human rights as requirements. This thesis adopts a Hohfeldian approach. A right, under this conception, is fundamentally a personally oriented requirement whose existence depends on a person acting 'by right', that is, in accordance with a duty owed to him by another. Hohfeld found that rights generally consisted of four general 'incidents'. This thesis is concerned mainly with the *claim* whereby S can claim of an official (O) that he has a duty to allow S to undergo enabled suicide. This is what is meant by a 'claim-right'. Generally, unless otherwise indicated, references to a 'human right to enabled suicide' will refer to a 'Hohfeldian human claim-right to enabled suicide'. Claims to enabled suicide that may be made by all people 'by right' against UK officials form the basis of the analysis in this thesis. The constituent elements of such a claim-right are examined below (2.2.3), but it is useful firstly to consider and reject certain preliminary objections to such a Hohfeldian conception of human rights in order to defend this premise.

The first objection is that while Hohfeld's scheme may have merit when applied to domestic legal or moral rights it cannot apply to such a diffuse and abstract concept as a human right (Chwaszcza 2010, 335*ff*.). The reasons advanced for such a position are multifarious, but in essence they are that individual rights require a significant degree of moral or legal agreement and this does not exist. In particular, it is argued that there is no consensus that humans *possess* rights even if there is a degree of consensus that they may *deserve* rights (Chwaszcza

[2] The reason that the usage of the term 'rights' is emphasised is that a standard definition of a right is a personally oriented requirement, and theorists who deny that human rights should be understood as creating personally oriented requirements also argue that human 'rights' should be understood to be principles (eg Chwaszcza 2010).

2010, 335*ff*.).[3] This objection is a long-standing general objection to the validity of human rights.[4] The second, related, objection is that the responsibility of the State to secure human rights cannot be defined in terms of personally-oriented duties (eg Phillipson and Williams 2011, 900*ff*.). In other words, only the State can infringe a person's human rights. This objection illustrates the importance of the distinction between 'applicability' and enforcement of Hohfeldian human rights. The concept of 'applicability' is that Hohfeldian human rights are possessed by all persons and everyone in turn must respect them (Beyleveld and Pattinson 2002, 626*ff*.). It is, however, primarily the business of States, with their infinitely greater organisational resources, to resolve questions of enforcement of our human rights as a matter of law (Beyleveld and Pattinson 2002, 631*ff*.).

These objections illustrate different aspects of Hohfeldian human claim-rights which form the premise of the analysis in this thesis. The first objection is *prima facie* an attack on the practical utility of human rights.[5] However, Chwaszcza seeks to argue that denying that human *rights* exist as practical concepts within individual States does not deny the validity of 'human rights' (Chwaszcza 2010, 348*ff*.). It is the concept of human *rights* as practical concepts that are assumed to be valid by this thesis. It is submitted that this assumption is defensible. The UK has accepted responsibility for upholding human rights by ratifying the ECHR,[6] and it was the human rights of Pretty, and various later claimants, that have defined the character of the current domestic legal debate on assisted suicide and voluntary euthanasia. The second objection, meanwhile, merely serves to emphasise the importance of the distinction between applicability and enforcement. It is not, of course, the premise of the analysis in this thesis that a human right to enabled suicide must be validly enforced by individuals; rather, the premise is that human rights give rise to corollary obligations on all persons (eg Gewirth 1982). The UK's responsibility to secure human rights is therefore to

[3] Alternative accounts of international human rights treaties seek to establish an expansive concept of 'human rights' as 'standards' or 'goals'; if the State meets the standards then it 'qualifies' as being a liberal democracy; claimable rights relevant to these standards would exist only at the national level (Chwaszcza 2010, 348*ff*.).
[4] The criticism that human rights are without foundation is an established criticism of human rights law and theory, an example of which is Bentham's famous criticism of human rights as 'nonsense upon stilts' (1843).
[5] The validity of human rights is not defended in this thesis; rather it is a foundational assumption that human rights are accepted as valid.
[6] Article 1: 'The High Contracting Parties shall secure to everyone within their jurisdiction… rights and freedoms.'

ensure that those within its jurisdiction do not interfere with each other's rights as much as it is to refrain from such interferences itself.

2.2.3 The constituent elements of a human right to enabled suicide

Borrowing Gewirth's terminology, the structure of a human right to enabled suicide can be expressed as follows: a human subject has a valid claim-right when he has a valid claim to an interest (Φ) (which is that the enabler E enables his suicide) against another respondent on the basis of a principle capable of justifying the possession of such a right to such an interest by all human persons (expanded from Gewirth 1982, 2). Put in terms of the hypothetical requests to "take my life," "help me die," "end my suffering" and "let me die", the suicidal claimant (S) is the subject of the right, or the rights-holder – an official empowered to interfere with S's request (O) is the respondent of the right, the person holding the correlative duty, or duty-bearer. The justifying basis of the right is the criteria by which it may be established that these are valid elements of a right, or its 'foundational principle(s)'. This basis must be something applicable to all humans.

Elements of a Hohfeldian claim-right and justifying basis	*The request for enabled suicide as a claim to a human right to enabled suicide*
Subject	The person requesting enabled suicide (S)
Object	The interest of the person seeking enabled suicide in achieving that purpose by being enabled (by the enabler (E))
Respondent	The official empowered to interfere with the request of the person seeking enabled suicide who bears the duty of S's claim if it is valid (O)
Justifying basis	The foundational principle that justifies the elements of the right on a basis that is applicable to all humans or 'everyone'

2.2.4 The nature of a Hohfeldian human claim-right to enabled suicide

The concept of a claim-right is compatible with different accounts of the nature and significance of S's *claim* or 'exercise' of his right to enabled suicide which gives rise to O's resultant duty. There are two broad approaches to the significance of a claim: the will-theory

and the interest-theory. The will-theory conception of claim-rights is adopted in this thesis. On this view it is the free exercise of a claim to the object of the right that is essential to the resultant duty. Feinberg terms this approach a 'performative' conception of individual claim-rights in his article 'The Nature and Value of Rights' (1970). This reflects one concept of the function of such rights as necessarily something individuals exercise, so that the duty of the respondent is 'whole' when the individual exercises a claim over the object of the right (Hart 1982, 185; Feinberg 1973, 75). An example of the intimate relationship between free exercise and the existence of rights is that of property rights in which an owner's freedom to use or dispose of the land is what makes it meaningful to refer to the owner possessing a 'right' in land. Feinberg described the necessary characteristics of such claims as being duties *controlled* by the subject, on the basis that such duties turn on the existence of a claim made by the individual rights-holder (1970).

The alternative 'interest-theory' of rights is that the duty arises solely due to the importance of the interest. Unlike property rights the claim is one that must *inherently* be made by humans, because the object of the right is inalienable and fundamental to humanity, so cannot be extinguished or assigned to others (eg Finnis 2011, 198*ff*.).[7] On this conception of rights, they are granted to the individual for his own good, and do not thereby imply control over the interest for which the right is granted (MacCormick 1977). Where a claimant's interests conflict with the interests of potential claimants the importance of the two interests must be weighed by reference to a relevant criterion in order to establish the resultant duty (eg Waldron 1984, 15; Letsas 2007, 100).

In order to justify adopting the will-theory approach to a human right to enabled suicide a justifying basis must be defended. The justifying basis, which also prescribes the constituent elements of such a right, is therefore crucial. The justificatory basis adopted in this thesis, Alan Gewirth's theory of human rights as generic rights of agency (1978, 64), defends the

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[7] The inalienability of human rights has formed the basis for the argument that such rights cannot be meaningfully said to be under the 'control' of a claimant, since he is unable to give up the interest in the right, or assign it to another (eg MacCormick 1977, 196).

> 'If there be no power to waive or assert the… claim… upon some matter, upon that matter there is no, *by definition*, no right either.' (Emphasis in original)

However, this argument has not been widely regarded as a decisive objection to regarding fundamental human rights as being under the performative conception (eg Simmonds 2001, 228 *f*.).

significance accorded to claims within a will-theory of such rights. This is discussed further below (2.5 and in chapter 4). However, if this theory is to be used to analyse *Convention* rights then it is necessary to defend adopting such a Gewirthian justifying basis.

2.2.5 Conclusion

If a Hohfeldian conception of human rights is valid then the existence and nature of a human right to enabled suicide depends on the elements of such a right, as defined above. The analysis of Convention rights and the responsibilities of the UK to secure these rights can therefore be broken down into these elements. The various requests to "take my life," "help me die," "end my suffering" and "let me die" engage the UK's responsibility to uphold Convention rights *if* the basis upon which people possess such rights does not contradict enabled suicide as a valid interest. Furthermore, the way in which Convention rights engage such concerns depends on the significance of rights-concepts such as 'claiming' and 'exercise of the right'. The next chapter will examine the nature of Convention rights in Hohfeldian terms, and consider the ECtHR's current approach to the interest and nature of a Convention right to enabled suicide after *Pretty*.[8] Before so doing it is necessary to consider further the justifications that could be advanced for a human right to enabled suicide and defend a Gewirthian justificatory basis for human rights. The question of justification, put in Hohfeldian terms, is a question of which of various possible moral bases of human rights are to be preferred.

2.3 The justificatory basis of a moral human right to enabled suicide

The existence of a morally valid claim by the suicidal claimant (S) to suicide (enabled by E) against an official empowered to interfere (O) depends on advancing a moral justification for O's duty that applies equally between *all humans*. The concept of morality itself is, of course, contested, and this thesis does not attempt to defend or define morality or the existence of moral rights (it is an assumption of this thesis that morality and moral rights exist). However, it is necessary to outline briefly the idea of morality as providing the foundation of the

[8] *Pretty v UK* (2002) 35 EHRR 1.

concept of moral rights in this thesis. The idea of morality in this thesis is personal and action-guiding: morality is defined (stipulatively) as an attempt to impose categorically binding standards for action. To break this down further, morality refers to the following concepts:[9]

1) *Prescriptive imperatives* (which purport to be action-guiding and to address others)
2) that are *Categorical* (binding regardless of inclination, and prevailing over other 'imperatives') and
3) *other-regarding* (un-egotistical in that the requirements concern the interests of others).

On the basis of the concept of morality set out, how does one defend adopting a Gewirthian approach that is capable of justifying a human right to enabled suicide? Before this question can be addressed in full it is necessary to consider the various alternative approaches and the way in which they differ as regards a human right to enabled suicide (a final answer to this question is provided in chapter 4). Moral argument about whether a human right to enabled suicide is justified suffers from entrenched disagreement (see eg Griffin 2008, 212*ff*.). The dominant camps in Western legal/moral theory – rights-utilitarian, deontological duty-based and rights-based approaches – differ in their responses to the validity of such a right. The grounds on which they differ are founded on the values of life and self-determination and the relevance of suicide to these values.

The next section (2.4) will primarily consider and seek to reject the sanctity of life position defended by John Keown, which denies the validity of a human right to enabled suicide. There are various alternative possible moral arguments for rejecting the duty-based theory that provides the foundation for this view. This thesis will consider the two main moral camps in Western ethics that are capable of accepting the validity of a Convention right to enabled suicide: firstly the rule-utilitarian position that human rights must fundamentally respect human experience of life and that enabled suicide may be defended when people seek to end a degrading and undignified existence, and, secondly, the deontological rights-based

[9] The form of this definition draws on Pattinson's formulation (Pattinson 2002a), which itself derives from Gewirth 1978, 1.

position that self-determination is inherent in all fundamental *rights* and therefore that the right to life grants the rights-holder the right to suicide. A version of the latter argument, Gewirthian rights-based theory, is defended in this thesis (2.6).

2.4 The sanctity of life view and duty-based moral theory

2.4.1 Introduction

The sanctity of life view is strongly associated with religious faith-based argument, but it is the secular moral argument for this value that is considered in this thesis, and in particular the approach of Keown. On this view the enabler (E) acting upon the suicidal claimant (S)'s "take my life" claim is no better than a murderer, since the near-absolute value of life defended by this theory denies that any action to end the life of another intentionally is permissible. Similar objections are raised to E's action in the "help me die" situation. However, the "end my suffering" and "let me die" claims represent a challenge to the sanctity of life view; theories seeking to defend that position must either reject these intuitively appealing claims or seek to distinguish them from general claims to enabled suicide. To defend limited acquiescence to these claims without general recognition of the "take my life" or "help me die" claims, Keown refers to the deontological duty-based moral theory that provides the foundation for his view, which is closely related to the natural law-based approach of Finnis.

2.4.2 The sanctity of life view

The sanctity of life position claims that human life is a near-absolute good. This view is strongly linked to religious, particularly Judaeo-Christian, moral theory (eg Sacred Congregation for the Doctrine of the Faith 1980)[10] which is why this position is associated with the view that life is 'sacred'. The theories of Keown and Finnis are advanced in secular terms: 'sanctity of life' is a claim that human life is inviolable (eg Keown 2002, 40). On either a theological or secular view the life of human beings has a transcendent as opposed to

[10] See also Board for Social Responsibility of the Church of England 2000; Bayertz 1996; Wicks 2010.

an immanent value (Finnis 2011, 83*ff.*). A religious explanation for valuing life in this way refers to the distinction drawn between a man's earthly possessions, which he has a right to control, and his divinely given life, over which he does not have such a right (eg Aquinas 1274, II-II Q64 A5). On this view life is not 'possessed' by an individual for him to determine, but is sacred to God. Suicide is considered wrongful because ending one's own life is morally similar to ending the life of another. When the value of life is distinguished from all other values and all human experience suicide can be viewed as committing 'self-*murder*' (Aquinas 1274, II-II Q64 A5).[11] This theological position translates into the secular position defended by Keown and Finnis.

Keown's secular expression of the sanctity of life argument finds that the value of human life stands above, and is distinct from, all other values as the source of human capacity for unique dignity and reason (see Keown 2002, Ch 4). On the 'sanctity of life' view the most fundamental human right is the right not to be intentionally killed, and enabling suicide is impermissible involvement in intentional killing (Keown 2002, 41). In terms of human rights and the ECHR Keown argues that the Convention was intended to protect all forms of human life, since such protection is integral to maintaining equal concern and respect for all humans; therefore the rights cannot be prayed in aid to allow access to enabled suicide (Keown 2002, 39*ff.*).[12] The idea that assistance in the intentional taking of another life is always wrong, even when the individual wishes to die, is associated with a view that such an act is contrary to natural law, forming the foundation of human rights (Battin 1996, 41-48). Keown also argues that there is a similarity between assisting suicide and murder of another, but does not suggest that this is necessarily on the basis that individuals' lives are the possessions of a divine being, but rather that such assistance violates the moral duties we owe to ourselves (Fisher 1995; Keenan 1996, 10-15; Keown 2011, 33).

Keown defends his view on the basis that the unique dignity of a human being that lies at the foundation of human rights is most fundamentally a commitment to protect the lives of

[11] The idea of self-murder has a long history; in terms of Christian thought it found purchase in Christian theory after the writings of St Augustine in 5th Century AD, and was taken forward by Christian thinkers such as Thomas Aquinas, whose arguments underpin modern objections to enabled suicide (see also Gormally 1994).

[12] Keown adopts various distinctions to justify certain forms of enabled suicide that, he argues, diminish the intention or action of the enabling individual; this reflects his duty-based deontological moral position: see further below (2.4.3) and 7.2.

human beings (eg UDHR Preamble). He argues that the value of human self-determination, claimed by right to die proponents as defending the right to suicide, in fact supports his position. He bases his argument on an interpretation of the value of the right to self-determination in terms of *human capacity* for autonomy (2002, 40; Wicks 2010, 46-7, 239-40). He argues that a narrow conception of self-determination as freedom to choose rationally would be nonsensical, since that would fail to protect *human* rights, since many humans cannot plausibly be considered to act freely and rationally (Keown 2002, 66*ff.*). He argues, on this basis, that suicide is contrary to human rights since it is the action of a person who, by definition, does not value their life as they *should* if the premise of human rights, that all humans possess an intrinsic dignity, is valid (2002, 53*ff.*). He argues that the protection of human rights extends to a requirement that States prohibit assisted suicide and voluntary euthanasia for those suffering unbearably ("end my suffering") or who are in the final stages of terminal illness ("let me die") (eg Keown 2002, 280-1; 2011, 314; 2012, 170-2). He argues that the claims in these situations, just as in the "take my life" and "help me die" situations, contradict the assumption that the continuation of human existence can never *in itself* be contrary to human dignity.

The sanctity of life approach *prima facie* makes an absolute moral claim as to the goodness of the continuation of human 'vital signs', and this claim has been subject to challenge throughout its history as an ethical position in Western ethics (eg Amundsen 1989).[13] Ethicists critical of this value, holding various ethical positions, agree that there are some circumstances in which 'merely' living without capacity to enjoy life is not valuable. Modern criticisms of the sanctity of life approach to enabled suicide in Western societies focus upon the fact that advances in healthcare provision mean that more people die of chronic illness and/or old age (eg Price 2007; Dworkin 1993, 81-4, 237-8).[14] The result is that many people face a prolonged dying process and experience a degraded experience of life which some seek to end prematurely. In certain narrow instances Keown seeks to modify the historic emphasis in sanctity of life doctrine on medically preserving life in order to avoid the

[13] Keown argues that his position is that life is not a fundamental good (which he characterises as 'vitalism') but a *basic* good, valuable only as it is necessary to experience (2002, 40); however, he denies that the ability to choose to continue to live defines the value of life. This position has been criticised as inconsistent, and that Keown's application of the sanctity of life position to enabled suicide reflects a stance based on the life being valued as a fundamental good (eg Price 2007; see further 7.2).

[14] See also discussion of such criticisms by Huxtable (2007, 10*f.*), and Sumner (2011, 74*ff.*).

intuitively unappealing results of compulsory prolongation of life. In particular he argues that his conception of the moral commitment to the sanctity of life does not impose a duty on individuals to have their life artificially drawn out by modern palliative care (2011, 89-93). He argues that limited relief to certain enablers and claimants in the "end my suffering" and "let me die" situations is therefore justifiable.

2.4.3 Duty-based theory

Finnis and Keown defend the sanctity of life view on the basis of a duty-based theory of natural law (Keown 2011, 7, 333; Finnis 2011, 211*f.*). This duty-based theory derives obligations from the fundamental interests that enable people to achieve their unique capacity for reason and self-determination.[15] However, this does not imply that a person's own disposition towards his interests is crucial, since it is possible for him to fail to understand what is in his true interests (Finnis 2011, 232; Keown 2011, 18). The criteria for defining these interests are what is most required for a person to *develop* the practical reasonableness that makes him uniquely valuable (Finnis 2011, 118*ff.*). Applied to the UK's responsibility to uphold human rights, its first responsibility is to secure the right to life for those in its jurisdiction, because life is among the most fundamental *interests* of people (Finnis 2011, 118*ff.*). The UK must therefore require its officials to abstain from interference with the right to life as well as requiring interference with those under its jurisdiction who participate in lethal enterprises against each other, including enabled suicide (Finnis 2011, 210*ff.*). This means that the definition of the fundamental interests in life is crucially important to the UK's responsibility under duty-based theory (eg Finnis 2011, 213*ff.*).

As regards the right to life, the relevant concept of life is 'every aspect of the vitality… which puts a human being in good shape for self-determination' (Finnis 2011, 86). The interest is objectively valuable in two senses: reference to the subject's assessment of the interest is unnecessary to demonstrate its value for self-determination, and the best possible judgment as to *what* constitutes 'life' is strictly required by the moral theory, so that an *ad hoc* or 'bottom up' moral judgment is insufficient (Finnis 2011, 69-75). The State's responsibility to secure

[15] I.e they are obligations for an individual to take or refrain from taking some action that affects the wellbeing of other agents.

the right therefore denies the validity of a right to enabled suicide, even if it is claimed, as it is in the "take my life," "held me die" and other situations, that suicide is a rational choice expressive of self-determination. Furthermore, the State's responsibility to protect the right to life would generally require that criminal sanctions would be imposed for all intentional taking of life, including rational suicide (Finnis 2011, 223*ff*.). It would also appear, *prima face*, that the State is required to interfere in the "let me die" and "end my suffering" situations. However, as regards the latter claims Keown seeks to justify the application of a 'double-effect' principle to certain narrow situations in which "let me die" and "end my suffering" claims are made, thus, in effect permitting 'enabled suicide' indirectly (although he would, of course, reject this characterization).

The principal distinction Keown defends is between the intention and conduct of a doctor refraining from artificially prolonging life, and the intention and conduct of a person enabling suicide (Keown 2011, 8-12).[16] This is the principle of double effect. Finnis also defends this principle (eg 2011, 122-24). Keown and Finnis argue that the State's primary responsibility to uphold the sanctity of life and secure the human right to life is to prevent the *intentional* deprivation of life. They argue that a doctor who intentionally withholds or withdraws life-sustaining treatment does not intend the patient's death and *may* therefore avoid moral responsibility for the resulting death (eg Finnis 2011, 122-23). Even more controversially, a doctor who 'incidentally' shortens life by giving pain-relieving palliative care is also deemed not responsible for so doing (Keown 2011, 9-12).

In outline, the principle of double effect relies on an application of the criterion of moral responsibility of a human agent's reasoned choice to act, so that ethical significance is accorded to the conceptual distinction between an intention to achieve the end result and believing, risking, or merely causing the end result (Keown 2011, 8-10). This is uncontroversial as regards merely causing a consequence to occur without subjectively recognizing that it would be likely or certain to do so. However, this notion is problematic where an agent acts in a way that he knows will create a significant risk (especially of the order of virtually certainty) that a lethal outcome will result from his action, as in the "let me

[16] See also 7.2 for further discussion.

die" and the "end my suffering" situations. Nevertheless, Keown argues that the actor does not possess intention, properly defined (eg 2012, 143). But, as has been pointed out by those attacking Keown's position, a slight difference in the enabler's (E's) action or knowledge is sufficient to transform his action from permissible to impermissible, which undermines the practical utility of the double effect principle applied to such situations (see eg Bennett 1981; McGee 2011, 827-31).[17]

2.4.4 Conclusion

The sanctity of life view represents a straightforward and intuitive conception of the value of life as a fundamental interest. However, the difficulty of reconciling it with its intuitively unappealing applications to the "end my suffering" and "let me die" claims has undermined its credibility as a basis for human rights (Wick 2010, 207*ff.*). The principle of double effect advanced to justify limited recognition of such claims is widely regarded as problematic. Advocates of the principle, such as Keown, respond that criticisms of inconsistency are overstated and the subtleties of double-effect ignored (Keown 2012, 142-43). As the next chapter will demonstrate, the sanctity of life view, and the duty-based interpretation of human rights advanced to defend it have been undermined as plausible accounts of the ECHR as regards enabled suicide.[18] Nevertheless, if a right to enabled suicide is to be defended as an ethically rational Convention right then the sanctity of life approach must be comprehensively rejected. Chapter 4 will therefore seek to demonstrate that the Gewirthian justification adopted provides a superior account of Convention rights as rational requirements.

2.5 The right to commit suicide: quality of life and inviolability of agency

2.5.1 Introduction

[17] See also Davis 1984 and Price 2006.
[18] *Haas v Switzerland* (2011) 53 EHRR 33, *Ulrich Koch v Germany* (2012) (App no 497/09) judgment of 19th July 2012, *Gross v Switzerland* (App no 67810/10) judgment of 14th May 2013. See further 3.4.3.

The moral value attributed to life that is defended by rule-utilitarian and rights-based moral theorists differs in fundamental respects from the sanctity of life view set out above.[19] Utilitarians defend life as having an instrumental value because, they argue, life enables us to have positive experiences, and our fear of being killed undermines our enjoyment of our lives (Glover 1977, 194*ff*.). In other words, for a utilitarian, the *quality*, as opposed to the quantity, of life is the reason that life is valuable (Seneca *4BC-65AD*). An alternative view is that life is valuable because *free* agency is uniquely valuable and life is the basis for that. Unlike the duty-based sanctity of life view to the effect that human agency is uniquely valuable and therefore that our fundamental interests must be preserved regardless of our dispositions towards them, the rights-based view finds that *freedom* is essential to valuing our lives (eg Beyleveld and Brownsword 2001, 263). This position, which may be termed the 'inviolability of agency' position, is most readily defended from a deontological rights-based perspective. This chapter proceeds in 2.5.2 to consider the quality and inviolability conceptions of the value of life. It then (in 2.5.3) considers the rule-utilitarian and (in 2.5.4) rights-based positions advanced to defend them. Chapter 4 will set out the reasons for preferring the Gewirthian rights-based approach as opposed to other approaches, including rule utilitarianism.

2.5.2 Quality of life and inviolability of agency

Advocates of the quality of life approach consider continued life to be valuable when it contains 'good' experiences. On this view, it is not *life* but the experience of life entailed by existing that is valuable. Life is therefore of instrumental value to a person in that his experiences are of sufficient quality for him to enjoy his life (Harris 1995, 10*ff*.). This view gained favour briefly in Renaissance Europe alongside the early development of European liberalism and human rights (Minois 1999, 86*f*.; Griffin 2008, 9*ff*.).[20] As regards enabled

[19] There is a degree of overlap between the rights-based and rights-utilitarian conceptions of life and it is important not to overstate the commitment to any one conception within either camp.

[20] An example of this is the work of clergyman/metaphysical poet John Donne whose Biathanatos (1608) illustrates his sympathy to the reasoning process behind rational suicide: 'Whensoever any affliction assails me, mee thinks I have the keyes of my prison in mine owne hand, and no remedy presents it selfe so soone to my heart, as mine own sword. Often meditation of this hath wonne me to a charitable interpretation of their action, who dy so: and provoked me a little to watch and exagitate their reasons, which pronounce so peremptory

suicide the continuation of a person's existence which is characterised by negative experiences, for example extreme suffering, is viewed as not being in his interests (Huxtable 2007, 15). Therefore where a person's condition is one of persistent suffering, or he is 'tired of life' (eg SOARS 2014), it is argued that no moral duty should be imposed upon him to continue his life, or on others to require that another should abstain from ending it at his behest (Singer 1993, 83*ff*.). The conception of life as instrumentally valuable to human interests is connected to the function of human rights as protecting the fundamental experiences of humans, which include, most significantly, fundamental human physical/psychological integrity or avoidance of extreme suffering (eg captured in Article 3 ECHR).

The instrumental value of life under a quality of life view may be contrasted with a further approach, which finds that it is not enjoyment of experience but the willed continuation of agency that is valuable. On this view an individual who wishes to commit suicide (who does not will to continue his agency) is morally entitled to do so, and others may be under a duty to enable him to do so (eg Doyal 2001). This conception of life is sometimes described as being based on the value of being able to choose life's worth for oneself (Huxtable 2007, 13); it is the life chosen autonomously by a person that is viewed as having intrinsic value on this view (eg Dworkin 1993, 217; Doyal and Doyal 2001). This value can be described as the 'inviolability of agency' because intentional destruction of free agency is always impermissible. It is necessary to distinguish the conception of the inviolability of agency under rights-based theory from the duty-based sanctity of life position considered above. Briefly, the rights-based view finds that a suicidal purpose does not necessarily contradict one's unique value as a human with the capacity for agency (eg Beyleveld and Brownsword 2007, 273). On this view it is *only* a self-aware person with the capacity for agency who is able to decide to 'determine' his existence by bringing it to an end at his instigation (Harris 1985). Controversially, on the rights-based view, where suicide is a freely chosen purpose then it is one that is arguably capable of having a similarly fundamental value to the choice to continue to live (eg Ford 2005). Interference designed to frustrate a suicidal purpose is

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judgements upon them' (Donne 1608, 1-2). The work goes on to express the view that rational suicide should not be considered immoral, contradicting the prevailing Christian thought of previous centuries. The enlightenment philosophers drew upon classical Greek philosophers, most famously the Stoics (prevalent 332BC-180AD eg Seneca (4BC-65AD: letters 70, 77)).

therefore potentially as serious a violation of the fundamental rights of a free agent as is (unwanted) killing of that agent (see 4.4).

The inviolability of agency view of the value of life captures another theme that is prominent in contemporary human rights discourse, which is that of protecting individuals from undue interference with their freely chosen purposes regarding their fundamental interests, even if those purposes are judged to be self-destructive (eg Lewis 2007, 14-15). Moral and legal human rights arguments for enabled suicide refer to the 'dignity of human life' requiring *control* over the continuation of one's life, regardless of the quality of one's experiences (eg Harris 1985, 15-18; see also *Pretty v UK* discussed in chapter 3).[21] This is illustrated by the popular call for 'liberty at the end of life' that lies behind calls for human rights-based reform in the context of prohibitions upon assisted suicide and voluntary euthanasia in Western countries (eg *Pretty v UK*).[22] As Dworkin puts it: '[m]aking someone die in a way that others approve but she believes is a horrifying contradiction of her life, is a devastating, odious form of tyranny' (1993, 217). Libertarian arguments refer simply to a liberty to die, stemming from the notion of self-ownership (eg Battin 1996, 163–164). More prevalent, however, is the argument for autonomous suicide, so that only competent agents possessed of relevant understanding are able to exercise the right (Battin 1996, 115).

The inviolability of agency position as a basis of rights-based legal reform necessitates strict safeguards to minimise the occurrence of insufficiently wanted or informed suicide occurring (eg Beyleveld and Brownsword 2001, 263). An individual who committed suicide when subject to coercion or under false premises would have suffered a violation similar to that suffered by a person who had been murdered (Beyleveld and Brownsword 2007, 274). The risks created by certain forms of enabled suicide, taking into account requirements of law and public policy, might therefore justify prohibition (eg Beyleveld and Brownsword 2007, 273*ff.*; see further chapters 5-9).[23] There is therefore a limited possibility for agreement between the natural law-based sanctity of life view and the inviolability of agency view. In

[21] (2002) 35 EHRR 1 [58].
[22] *Ibid*.
[23] Perhaps the most frequently raised objection to extending enabled suicide is that the conceptual and evidential difficulties created by the challenge of permitting rational suicide while preventing 'irrational' suicides is too great (eg Keown 2002, 72*ff.*).

particular, the threat of a 'slippery slope' to unwanted killing raises a crucial challenge to the argument for the right to enabled suicide under an inviolability of agency view (Dworkin 1991, 216; *cf* Keown 2012, 101).

2.5.3 Rule-utilitarian approaches

The view that what is morally right is the maximization of the wellbeing or welfare of a community provides the foundation for all utilitarian approaches; versions of utilitarianism that support 'fundamental' rights, such as human rights, are rule-utilitarian (eg Brandt 1992, 199).[24] This theory cannot, of course, justify human rights' peremptory status in relation to a particular community's welfare, but rather accepts such rights as being particularly weighty considerations in the utility calculus, so that the State's responsibility to secure a person's fundamental right is only displaced where so doing would be severely detrimental to the welfare of the community (eg Glover 1977, 83-85). A rule-utilitarian approach does not directly support the Hohfeldian conception of a human right above, but a rule-utilitarian position can be advanced to defend that conception indirectly, and rule-utilitarianism has been advanced as a basis for the Convention rights (Dembour 2006, 68*ff*.).[25]

The basis of community wellbeing/welfare in terms of utilitarianism is a utility calculus based on an aggregate calculation of the wellbeing of all individuals in that community; rule-utilitarians argue that the adoption of rules in the form of rights is defensible since if they were not recognized that would undermine the overall experience of wellbeing (Battin

[24] As is obviously well established, utilitarianism is contrasted with deontological theories in that moral rightness relies on the future consequences of actions for all, rather than on the actions in themselves for individuals (see eg Kagan 1998). For the purpose of this section it is only necessary to outline the fundamental characteristics of utilitarianism, which is summed up by the classic (act) utilitarian claim that a person's action is morally right if it 'maximizes the good' (Bentham 1789; Mill 1861; Sidgwick 1907), so that on a calculus of good outcomes against the bad the good outcomes are maximised. The nature and measurement of this good, within classical utilitarianism, is a hedonistic measure, calculating the pleasures and pains (of people) associated with the consequences of an act, rather than abstract values such as 'life' or 'autonomy' (see eg Hutcheson 1755). The interests of all people are equally counted within the calculus, and these interests are capable of being aggregated. In terms of personal action it is the actual (rather than foreseen) and direct consequences of an act which should be focused upon.

[25] Utilitarian ethicists argue that human rights are better characterised as advancing of utility within societies that adopt a common morality (Talbott 2005, 134; Nickel 2006, 47).

1996).[26] The utility calculus is not a 'vitalist' calculus that maximizes life; such an approach would, of course, undermine the welfare of the community, which would then devote its resources to a unlimited effort to sustain life (eg Harris 1985, chapter 4). Since the principle of utility (on a rule-utilitarian perspective) defends the quality of life approach, it does not in principle require recognition of a right to life that conflicts with a purported right to suicide or enabled suicide. On this basis the rule-utilitarian conception of the right to preserve life is inherently not in conflict with the right to discontinue life.

Sanctity of life theorists criticise this position as counter-intuitive since most people would find that living was more important than experiencing or 'choosing' (eg Finnis 1995). They further argue that the failure to account for the fundamental status of the right to life is part of a broader moral failing of the rule-utilitarian approach in that it cannot require that States accept fundamental moral rights without departing from the utilitarian premise of maximisation of community welfare (Finnis 2011, 213*ff*.).The preservation of life at great cost to the community creates a challenge for rule-utilitarians who seek to defend the weight accorded to a fundamental right to life by society (Keown 2002, 45*ff*). A utilitarian principle of welfare maximisation arguably struggles to defend adequately the intuition that certain aspects of the wellbeing of an individual should be deemed 'fundamental' and therefore unable to be weighed against the effect on the community created by protecting the 'non-fundamental' wellbeing of other individuals (eg Finnis 1995). A rule-utilitarian response to this criticism is that a right to *life* is justifiable, but not the near-absolute and intrinsic right to life that is defended by sanctity of life theorists (eg Glover 1977, 83-85). They defend the quality of life judgement on the basis that it is not mere existence that is intuitively valued by people (Harris 1985, 15-22). The continuation of existence is valued instead as the continuation of desired experience and agency (Cholbi 2011, 81*ff*.), rather than the human *capacity* for agency and experience (as Keown argues 2002, chapter 4).

In terms of the hypothetical claims to "end my life," "help me die," "end my suffering" and "let me die" (see 1.3.3.) a rule-utilitarian-based criterion would defend enabled suicide as an interest in all cases, but especially where the claimant was experiencing a low quality of life,

[26] The focus on generalizable maxims binding on all individuals within such theories brings it closer to deontological theories as regards protection for autonomy and rights (Brandt 1992).

as in the case of the "end my suffering" claim in particular (eg Almeida 2000). The justification for a right to enabled suicide from a rule-utilitarian welfare maximising perspective is primarily applicable to the situation where the claimant (S) desires that the enabler (E) should help him commit suicide when he is suffering or dying, and therefore the alternative to suicide is 'merely' preserving his life (perhaps also at great expense to himself and to his community).[27] The claimant's *choice* is not absolutely decisive in this case; rather, it is an interest that is taken into account alongside the quality of his life. For this reason possession of a right to the interest does not depend on control over it, so a rule-utilitarian-based human right to enabled suicide is not on the will-conception (eg Glover 1977, 158-62).

A rule-utilitarian approach to the State's responsibility to secure the human right to life when a person is suffering, as in the "end my suffering" situation is, *prima facie*, less pressing than the duty to preserve the right to life of the other hypothetical claimants (eg Brandt 1980; Almeida 2000). The distinction between the value of different persons' lives runs contrary to a founding intuition of moral human rights theory that all human lives are similarly valuable (eg Keown 2002, 40). The apparent difficulty of defending the equal value of lives as a basic good has formed a powerful basis for slippery slope criticisms of utilitarian-based arguments for voluntary euthanasia (eg Finnis 1995). Various critics highlight the inherent contradiction between utilitarianism and a principle of seeking to value lives equally (Keown 2002, 43*ff.*; Griffin 1989); they argue that reform based upon utilitarian premises would ultimately favour the healthy, 'inexpensive' members of a community and disfavour the vulnerable and sickly members (eg Keown 2012, 157-59).

The rule-utilitarian approach is influential in moral theory that defends a right to enabled suicide (eg Brandt 1992, 323*ff.*), and it provides a plausible interpretation of the findings as to Article 8 ECHR in *Pretty*,[28] which is considered in the next chapter. However, the criticism that autonomous suicide and euthanasia may in effect come to be conflated with marginally autonomous suicide and euthanasia by utilitarians is one that must be taken seriously (eg Gorsuch 2009, 172-76). The sanctity of life basis for such criticisms obviously goes further

[27] Controversially, on such a judgement it is relevant that the community could divert health resources to restore a greater number of healthier individuals members to a state of wellbeing (eg Almeida 2000).
[28] *Pretty v UK* (2002) 35 EHRR 1.

than would be supported on the rights-based position adopted in this thesis, but it is a criticism of theorists in both camps that the rule-utilitarian position does not justify protection of life to an extent that is compatible with the fundamental status of the human right to life (Dworkin 1993, 204; Gormally 1995). On this view the hypothetical claims to enabled suicide should therefore be of *equal* moral weight in principle. The rights-based approach is discussed in outline next, and the Gewirthian rights-based approach is further developed in 2.6 (and then in chapter 4).

2.5.4 Rights-based approaches

The rights-based defence of the human right to enabled suicide stems from the implicit commitment to non-interference with the 'inherent rights' of persons within such theories. The essence of rights-based morality is a supreme right, or a principle of rights. This supreme right, or principle of rights, then justifies the nature of discrete rights, such as the right to life. Deontological rights-based theories find consent to be integral to the existence of strict moral duties (eg Nozick 1974, 228), and consent is inherent in the conception of a 'right' which is relied on in this theory (Nozick 1974, 139; a right under the will conception (2.2.4)). Within this approach there are, broadly speaking two position: agent-centred deontological rights-based theories, and what Alexander has termed 'patient centred' theories (2004). The terminology refers to the distinction between a focus on action generally and the limited focus in patient-centred theories to an agent who is acted *upon*. Patient-centred deontology is based on self-ownership, and in particular on the right not to have one's body or property used as a means to create benefit for another without one's consent (eg Nozick 1974). Agent-centred rights-based theory, in contrast, identifies moral duties that are intrinsic to agency (Gewirth 1978, 77; Gewirth 1982) and in that sense is similar to the deontological duty-based theory of the sanctity of life considered above (eg Huxtable 2005). However, rather than focus on the duties to further an agent's interests, the focus of agent-centred rights-based theory is on duties to further an agent's exercise of control over his wellbeing (2.2.4).

Patient-centred accounts of rights-based morality are conceived in reason-giving or reason-blocking terms. Briefly, on this view, actions – particularly State actions – cannot be taken that are based on reasoning that treats a person to be used as a means (Letsas 2007, 101). Dworkin's statement of rights as 'trump cards' is compatible with this view (Dworkin 1977,

82-90) although Dworkin did not explicitly adopt a deontological position to defend his rights thesis. The construction of moral requirements under such theories can be agent-neutral, in the sense that a claimant possesses a right that requires 'everyone' to act to respect it (eg Alexander 2004), or agent-relative, meaning that there is a rational basis on which discrete agents should refrain from interference with the claimant's right (Gewirth 1978, 114*ff.*). It is the latter conception which is compatible with the Hohfeldian framework set out in 2.2, as discussed below (see 2.6).

In terms of the discrete right to life, deprivation of life is only impermissible if it involves non-consensual interference with another's body (Mack 2000). The response of such patient-centred theories to the right to suicide is emphatic in principle, regardless of whether the claim is "take my life," "help me die," "end my suffering" or "let me die" (1.3.3): it is axiomatic that officials should not interfere with another's body without his consent, irrespective of the life-preserving utility of the action (Cholbi 2011, 87*ff.*). Patient-centred accounts are *narrow* in their moral focus; this narrowness is criticised generally as an implausible account of morality (eg Scheffler 1988), and of human rights (eg Chwaszcza 2010, 347-8).

The agent-centred account of rights-based morality that will be explored in this thesis, that of Gewirth, does not adopt a narrow reason-blocking moral methodology. Gewirth's account sets out a supreme principle of rights in terms of the conditions of agency that are generic to all people (or agents). These generic rights support an agent-relative rule similar[29] to a Golden Rule principle (eg Flew 1979), which he terms the Principle of Generic Consistency (PGC): '[a]ct in accord with the generic rights of your recipients as well as of yourself' (Gewirth 1978, 135).[30] The generic *rights* to the conditions of agency are rights on the will conception (above 2.2.4) because the generic conditions of agency are necessary for an *individual* agent to value its purposes – in other words an agent-relative value. The agent-relative approach to the generic rights contrasts with the agent-neutral value ascribed to conditions of agency under other deontological supreme principles, such as the Categorical

[29] But distinct in crucial respects, in particular because the PGC sets out a principle with a necessary content and form (Gewirth 1978, 164*ff.*).
[30] This brief outline is expanded upon in 4.2 and 4.4.

Imperative (Kant 1785 (trans. Paton 1948), 88-89). Despite the focus on agency, the theory supports an extensive range of rights that are explicitly coterminous with human rights (Gewirth 1982). It does so by adopting a deontological consequentialist approach to the permissibility of actions (Gewirth 1978, 216).

Rights-based approaches are generally criticised on the basis that they are narrow, absolutist, and individualistic (eg Lewis 2007, 53-54; Mahoney 2007, 100*f*). The 'abstraction' of a supreme right is criticised for removing ethical concerns from *human* rights and restricting them instead to the rights of hypothetical agents (eg Ford 2005, 99). In addition to this overarching criticism it has been argued that the application of such theories to a human right to enabled suicide is rationally inconsistent (eg Ford 2005, 100).The rational consistency of rights-based theories is criticised in terms of their capacity to defend a human right to *suicide* which destroys the person or agent who is also held to be inviolate. Such theories are accused of either committing themselves to a position that accords an implausibly limited priority to preserving life in this circumstance (Ford 2005, 100), or of being committed to denying a right to enabled suicide on the basis that the inviolability of agency must in practice be realised by prohibiting intentional killing (Keown 2002, 40).

Rights-based theories, unlike rule-utilitarian theories, are committed to personhood as an *intrinsic* value so that the destruction of personhood cannot be held to be a benefit on the basis of unbearable suffering (eg Wicks 2010 181*ff*.). In this respect there is agreement between the sanctity of life position defended by duty-based deontology and the inviolability of agency position defended from the perspective of rights-based deontology. The capacity for rights-based theories to meet the apparent paradox of commitment to free-agency and to the self-destructive choice to commit suicide is crucial to their rational consistency and plausibility in defending a right to enabled suicide. An outline defence in these terms of a Gerwirthian rights-based approach to a human right to enabled suicide is made below (2.6), and is further developed and supported by reference to the ECHR and Gewirthian dialectical justification in the following chapters (3 and 4).

2.5.5 Conclusion

The above outline of the two broad approaches to the value of life demonstrates that both stem from very different moral traditions within Western thought. The significance of both positions within contemporary human rights law is illustrated by their relevance to moral judgements about the right to enabled suicide of applicants under the European Convention on Human Rights (ECHR), which is considered in the next chapter. If it is to be claimed that one approach to human rights law should be adopted then it is necessary to defend the adoption of such an approach from fundamental criticisms from either opposing view and from the sanctity of life approach. The entrenched nature of the moral camps is heralded as a reason for pessimism about such an attempt (eg Huxtable 2007, 139*ff.*). Nevertheless, this thesis will seek to demonstrate that the Gewirthian rights-based approach is to be preferred on the basis that it is superior to rival theories in terms of providing an ethically rational interpretation of ECHR rights. This approach is set out in the next section.

2.6 A Gewirthian rights-based approach to a human right to enabled suicide

2.6.1 Introduction

This thesis adopts Gewirthian theory to justify its initial stipulations that the Hohfeldian subject and respondent of a human claim-right to enabled suicide are persons/agents and that this right is exercised by waiver of the right to life. This approach commits the thesis to the inviolability of agency conception of the value of life and therefore to rejecting the duty-based sanctity of life view as well as the rule-utilitarian based quality of life conception. There are two fundamental objections to Gewirthian theory as a deontological rights-based justification which must be overcome if it is to serve as a theoretical foundation for a human right to enabled suicide (2.5.4). Firstly, it has been objected that rights-based theories are incapable of justifying a *human* right to enabled suicide since they do not provide a basis for granting moral status to humans, only to agents who are capable of exercising rights (eg Dembour 2006, 140). Secondly, it has been argued that a justification based on the exercise of rights cannot defend waiver of the right to life, since so doing destroys the capacity to exercise rights (eg Donchin 2000).

2.6.2 The constituent elements and nature of a Gewirthian human right to enabled suicide

The subject and respondent of a Gewirthian human right to enabled suicide are clearly agents, who are beings that have developed the capacity for reasoned action (Gewirth 1978, 64*ff.*). In terms of the hypothetical claims to enabled suicide ("take my life" etc, in 1.3.3) the subject is an agent who requests an enabled suicide (S) and the respondent is an agent official (O) empowered to interfere with S's request. No distinction is made between a respondent who abstains from acting to interfere with the right (a 'negative right') and one who acts positively (a positive right) to further it under the Gewirthian conception, in contrast to the position under patient-centred rights-based theories (Gewirth 1978, 67*ff.*; also see Narveson 2001). The conception of the interest and nature of the Gewirthian right to enabled suicide is less straightforward. Gewirthian generic rights are rights to interests that are needed for action, and suicide is transparently not something needed for action (Gewirth 1978, 136-37). The right to suicide can only be expressed as a right to maintain control over the *continuation* of agency as the foundation of action (Beyleveld and Brownsword 2007, 273). Beyleveld and Brownsword set out the negative requirements of an *agent*'s right to life as 'a negative claim-right that other agents do not act in ways that are intended to terminate one's life…' (Beyleveld and Brownsword 2007, 274). This raises the question of the status of assistance. Beyleveld and Brownsword propose another formulation of the negative right to life which highlights assistance as one aspect of that claim-right:

> …a negative claim-right that other agents do not take steps to assist others to terminate one's life or to assist one to terminate one's life… (2007, 274)

This atypical formulation is made to highlight the fact that assistance, one means of obtaining the right, has an *instrumental* nature in Gewirthian theory, so that the assistance is not to achieve the destruction of the agent, but to assist the agent in achieving its *purpose*. Avoiding the impermissible purpose of destroying an agent is logically only possible for an assister who is entirely acting to further the suicidal claimant (S's) suicidal purpose. This right can be stated as follows:

> A permissive right to take one's life;
> A negative claim right that other agents do not act in ways that are intended to interfere with an agent's exercise of permitted suicide under [the permissive right to take one's own life]

> A positive claim right that other agents assist one in exercising permitted suicide. (Beyleveld and Brownsword 2007, 275)

This thesis is in agreement with Beyleveld and Brownsword as to the object and nature of a right to enabled suicide. The object of such a right, as in the Gewirthian conception of the right to 'life,' is the continuation of agency, and the right is on the will-conception. In terms of the status of S's request, the discontinuation of S's life is *as fundamental* an exercise of S's right to life, as is its continuation. This illustrates the fundamental importance of freedom within Gewirthian theory as a rights-based theory. In terms of the enabler (E's) action, any interference with his enabling action represents an interference with S's right to enabled suicide. However, it is important to emphasise that where a relevant official empowered to interfere with E's action (O), has reasonable doubts as to whether S has truly chosen to end his life then he must act to prevent E violating S's generic right to life.

2.6.3 'Agent rights' or human rights?

The Gewirthian premise of 'agent' rights is controversial (eg Griffin 2008, 32*ff.*). Objections to this premise attack agent-centric rights-based theory as incapable of providing a justificatory basis for *human* rights (eg Ford 2005). The objection is, simply, that the subject of such right is properly conceived of as being human and not an 'agent', a narrower category. The effect of this, critics argue, is to narrow the scope of legitimate protection of human rights, with the result that basic human rights are denied to human marginal agents (see eg Cornides 2008). The protection of 'agent rights' is, facially, less intuitively appealing than of 'human rights', but the intuition that human rights should apply to 'humans' inevitably requires a judgement about what it is about humans that would merit the possession of such rights (Gewirth 1978, 99).[31] The main moral theories of human rights, discussed above, justify granting rights on different bases such as to beings capable of developing human capacity for reason (duty-based) and/or to beings capable of experience (rule-utilitarianism).

[31] See Ryder 1971 and Cavallieri 2001 for discussion of the 'speciesism' of according moral status to 'humans' as a taxonomic category.

Gewirth has conceded that what is meant intuitively by use of the term 'human' denotes a significantly broader category than does use of the term 'agent' (Gewirth 1978, 120). Beyleveld and Pattinson have accepted that certain human marginal agents of intuitive moral significance and conventionally protected by human rights are excluded from the ambit of direct protection of Gewirthian theory (eg 2000). However, Gewirthians, in common with other rights-based theorists, seek to justify the ascription of moral rights to humans who are not agents (eg Beyleveld 2011, 9-10). There are two possible bases for justifying according moral status to non-agent humans: firstly that human non-agents might benefit from rights proportionate to the degree to which they exhibit agency (Gewirth 1978, 142-44); secondly that all non-agents lack moral status, but that the application of moral rights *in practice* justifies ascribing moral status to possible agents to the degree to which they exhibit agency (Beyleveld and Pattinson 1998). This thesis is in agreement with Beyleveld and Pattinson's approach.

2.6.4 Enabled suicide as a valid object despite destroying agency?

The second objection is straightforwardly that the destruction of agency is a purpose that contradicts the inviolability of agency. This argument finds that if the inviolability of agency position is to be rationally consistent then it should adopt the sanctity of life approach and reject the human right to enabled suicide (Keown 2002, 40-41). This argument rests on a particular view of the nature of the value of agency and its relationship with human dignity as underpinning human rights (Keown 2002, 59*ff.*). In particular Keown argues that human dignity requires a person to act in accordance with his status as a dignified being, rather than to require that the choices of a person always be respected (eg Keown 2012, 172; *cf* Beyleveld and Brownsword 2001, 29*ff.*). The basis for this argument is the judgement that human rights are justified because they protect the development of *human* agency, and suicide does not serve this goal (eg Finnis 2011, 86). The argument is essentially that there is no defensible basis for separating the protection of agency from the protection of the physical and environmental factors that create and develop it (Ford 2005, 94). The perceived contradiction between valuing agency and suicide lies behind the criticism that there is a 'personhood paradox' at the heart of the right to die movement (Ford 2005).

Rights-based theorists who advocate an inviolability of agency position may defend the logic of protecting the choice to commit suicide as a right on the basis that it is the capacity for and *exercise* of choice affecting our fundamental interests that expresses the value of agency (eg Dworkin 1993, 190-92). Gewirthians observe that free purposing cannot be preserved by preventing agents from pursuing their purposes, even when these are self-destructive (Gewirth 1978, 136-37). In terms of the right to life it is an autonomous choice that is protected as a human right, and only where the decision to commit suicide is not clearly autonomous does the protection of human dignity require that such decisions should be treated as a 'cry for help' and disregarded (eg Dworkin 1993, 221-232). The basis of this argument in Gewirthian theory is explored further in chapter 4.

It should be pointed out that a Gewirthian may concede that the 'personhood paradox' is correct in so far as a 'right to *die*' is unsupportable from a position that upholds the inviolability of agency (Beyleveld and Brownsword 2007, 274). Gewirthians view agents as having interests in the generic conditions of agency, which are things all agents require if they are to act to fulfil their purposes, and death is clearly not among the interests that an agent requires to act (eg Beyleveld and Brownsword 2007, 274). However, this does not mean that the 'personhood paradox' contradicts a Gewirthian right to *suicide*. A right 'to die' is a misnomer and not a synonym for the right to enabled suicide in Gewirthian theory. Death is not among an agent's generic conditions of agency, but *freedom* to act is foundational to the generic rights to those conditions (Beyleveld and Brownsword 2007, 275).

2.6.5 Conclusion

The Gewirthian right to enabled suicide is not straightforwardly undermined by the two objections considered in this section. Despite this, such arguments against 'agent rights' and against the validity of a right to enabled suicide retain widespread acceptance (eg Chwaszcza 2010, 346*ff*.). To mount a full defence of the Gewirthian premise of 'agent rights' it will be necessary firstly to demonstrate the compatibility of the premise with the ECHR conception of enabled suicide (see chapter 3), and secondly to seek to provide further logical and moral reasons to adopt a Gewirthian supreme principle of human rights (see chapter 4).

2.7 Conclusion

This thesis will argue that a human right to enabled suicide can be established in Hohfeldian terms on the basis that an agents are the subjects and respondents, while the ‘agent right’ to life is the object. These elements fit the hypothetical claims to enabled suicide (i.e. “take my life,” “help me die,” “end my suffering” and “let me die”). The defensibility of such a conception of a right to enabled suicide requires a justificatory criterion to be advanced that is capable of defending the possession of such a right by all ‘humans’. Gewirthian theory is advanced to provide such a justification and to defend such a right from the moral and conventional objections considered in this chapter, and in particular from opposition based on the sanctity of life view. The following chapter examines the conventional acceptance of a Gewirthian right to enabled suicide under the ECHR, while chapter 4 will advance a defence of Gewirthian justificatory criteria in moral and logical terms.

Chapter 3: The ECHR and the right to enabled suicide in *Pretty v UK*

3.1 Introduction

This chapter will seek to establish whether the European Court of Human Rights (ECtHR) has recently adopted a position in its interpretation of Article 8 that is consistent with a right to enabled suicide. To this end the chapter will set out the constituent elements of that right as recognised under the Convention, and will examine in particular the interpretation of its object and nature by the European Court of Human Rights. The ECtHR arrived at a judgment as to the aspects of a right to enabled suicide in *Pretty v UK*.[1] The chapter will then turn to the ECtHR's interpretation of the UK government's responsibility in relation to that right. It will examine in particular the government's responsibility to safeguard the lives of people under its jurisdiction, and the scope for the government to argue, as it did in *Pretty*,[2] that this amounts to a legitimate reason to deny the right to enabled suicide.[3] The chapter will argue that while a Gewirthian conception of the Convention right to enabled suicide is a plausible interpretation of the Court's interpretation, further logical and moral reasons must be advanced to defend adopting such a conception against other plausible conceptions (the argument advanced in chapter 4).

The chapter begins with an outline of the basic conception of Convention rights in general; this topic is, of course, very broad, so all that is set out for purposes of this thesis is an outline of the relevant aspects of the familiar Convention text and the judgments that bear on the conception of a right (3.2). Having established this general outline, the chapter will turn to the specific claims in *Pretty* (3.3). These claims provide the foundation for the analysis of the ECtHR's approach to the *object* of a right to enabled suicide (3.4). This analysis will examine in particular the extent to which a duty-based sanctity of life view is still valid as an interpretation of the Convention right to life. The analysis will then turn to the *nature* of a Convention right to enabled suicide (3.5) and address the question whether the Court's

[1] (2002) 35 EHRR 1.
[2] *Ibid.*
[3] *Ibid* para 60.

approach is compatible with the will-conception. The chapter will finally turn to the UK government's responsibility to enforce a Convention right to enabled suicide (3.6).

3.2 Preliminary points: the subject and respondent of a Convention right to enabled suicide

3.2.1 Introduction

The Gewirthian conception of a Hohfeldian human right is that the subject and respondent of such rights are agents. In terms of the hypothetical claims ("take my life" etc, in 1.3.3) the subject, the person requesting to have an enabled suicide (S), must be an agent to claim such a right. Meanwhile the respondent, the official empowered to interfere with S's request, must also be an agent in order to bear the duty. These points do not bear directly upon the questions the ECtHR was required to consider in *Pretty* concerning a Convention right to enabled suicide, but it is useful, for the purpose of clarity, to outline these basic elements of a Convention right. The next sections will examine in greater detail the controversial questions of the interest and nature of a Convention right to enabled suicide, and the ECtHR's response to these in *Pretty* (see 3.3-3.5).

3.2.2 The subject of a Convention right to enabled suicide

The general goal of the ECHR is set out in the preamble, and in Article 1 of the ECHR, which refers to the Universal Declaration on Human Rights (UDHR). If these texts are read together they set out a requirement placed upon States to act in a way that does not interfere with, and advances, the: 'inherent dignity and…equal and inalienable rights' of 'all human beings' or 'everyone' (UDHR Preamble, Article 1; ECHR Preamble, Article 1). It is apparent that the text makes no clear judgment favouring a Gewirthian agent as a subject. However, it is sufficient for the Gewirthian approach to the subject and justificatory basis of human rights that the 'equal concern and respect' which vests in 'human beings', 'members of the human family', 'human persons' and 'everyone', clearly encompasses human agents. This is significant in this context because in order to decide to commit suicide a human agent must

have developed certain capacities (Beyleveld 2011; see 2.6.2).[4] As the term 'human' is indefinite and includes 'agents' (the most distinctive characteristic of the human species being the capacity for reasoned action), or rather 'ostensible' agents, the concept of an 'agent' right to enabled suicide under a Gewirthian conception is plausible (Beyleveld and Pattinson 1998). Therefore, in terms of the hypothetical "take my life," "help me die," "end my suffering" and "let me die" claims under the Convention, the suicidal claimant (S) *may* be an agent (1.3.3).

3.2.3 The respondent to a Convention right to enabled suicide

The individual respondent to any claim (obviously including to enabled suicide) is not precisely defined within the ECHR (Beyleveld and Pattinson 2002, 626). There is no question that the State has responsibility to secure Convention rights, but, as was discussed in 2.2.2, this is not a reason to find that such rights are not *applicable* between individuals. There is general agreement that the Convention can only be plausibly interpreted as setting out requirements on State bodies (eg Letsas 2007, 31) and that other individuals cannot be respondents to Convention rights. There are, however, instances in which individuals are understood as being capable of interfering with each other's rights in a way that engages the State's responsibility before the Court. This is referred to as indirect horizontal effect (Fenwick 2007, 215-16).[5] The Convention also recognises horizontal applicability in the sense that the State can resist a rights' claim on the basis that it must act to secure the 'rights of others', which includes their Convention rights, as reflected in the ECHR at various points.[6]

A more general horizontal applicability thesis is not widely accepted as an account of the Convention rights since the ECtHR has not taken opportunities to develop such a general

[4] This judgement as to evidence of agency applies to any case of apparent partial-agents in a hierarchy with a requirement that human beings exhibiting a capacity for self-determination and rationality be treated as full agents, and merely intelligent or purposive behaviour is accorded rights in proportion to the degree to which it evidences agency (eg Beyleveld and Pattinson 2000).

[5] A term from international law contrasted with 'vertical' effect which means that a right set out in an international treaty can be claimed against a non-State (non-public) body.

[6] See, for example, Article 17: 'Nothing in this Convention may be interpreted as implying for any... person any right to engage in any activity or perform any act aimed at the destruction of any of the rights… set forth herein…' (see further Beyleveld and Pattinson 2002, 629-31).

doctrine (Phillipson and Williams 2011). However, the idea at a conceptual level that individual persons can violate other individuals' Convention rights underlies the Convention and finds particular expression in relation to specific Articles. This is particularly apparent under Articles 8-11 paragraph 2 which provide that the primary right may suffer interference in order to protect the 'rights of others' (see, for example, Phillipson and Williams 2011, 881; *Von Hannover v Germany*).[7] That is less apparent in relation to Articles 2 and 3 which do not refer to the 'rights of others' (see for example, *ABC v Ireland*;[8] *Ilascu et al v Moldova and Russia*).[9] While an analysis that finds horizontal applicability within the Convention at a conceptual level may be regarded as artificial by domestic Convention lawyers (eg Phillipson and Williams 2011), it has not been demonstrated that it is incorrect as a plausible interpretation of the ECHR (eg Beyleveld and Pattinson 2002). On this view the respondent to the hypothetical claims to a Convention right ("take my life," "help me die," "end my suffering" and "let me die") are officials who are empowered to interfere with the claimant's right to enabled suicide (see 1.3.3). It is significant for the Gewirthian interpretation of the right to enabled suicide that the respondents, like the subject, are plausibly agents (see further 2.6 and chapter 4). As will be discussed in the next section (2.3) Pretty claimed rights under various Convention Articles, including those that are arguably more typically conceived of as vertically applicable (Articles 2 and 3), and those which at a conceptual level recognise horizontal applicability (Articles 8 and 9). As discussed below, this was arguably significant to Pretty's claim in an indirect sense (see 3.5).

There remains the further question as to what UK officials would have to do to give effect to a right to enabled suicide. The ECtHR has accepted that ECHR Articles are capable of imposing positive duties[10] that are limited by the capacity for the relevant actor to fulfil such an obligation.[11] The ECtHR has recognised such a positive duty under the Convention right

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[7] (2012) 55 EHRR 15 para 102.
[8] [2010] ECHR 2032 para 181 in which the Irish government raised the argument that protection of the foetus should be included within the 'rights… of others' and this argument was not decisively addressed by the Grand Chamber (see further Fenwick 2014).
[9] (2005) 40 *EHRR* 46 (2004) para 432.
[10] *Airey v Ireland* (1979) 2 EHRR 330 para 32. The view that rights are necessarily negative is associated with certain rights-based theories (eg Nozick 1974, 98-99).
[11] This position appears to follow the maxim 'ought implies can' (see further eg Cranston 1973, 68; Gewirth 1978, 67-68).

to enabled suicide in *Haas v Switzerland*[12] (see below 3.4.3). This interpretation is compatible with the Gewirthian right to enabled suicide, which is not restricted to a negative right to non-interference, although due to its nature nor is it straightforwardly a right to assistance (see 2.6; Beyleveld 2011, 14-15).

3.2.4 Conclusion

The subject of a Convention right to enabled suicide is capable of being interpreted compatibly with a Gewirthian right to enabled suicide, but that does not mean that the ECtHR is committed to such an interpretation above the other prominent moral theories considered in the previous chapter (i.e. rule-utilitarian, duty-based and rival rights-based theories; see 2.4, 2.5). This is unsurprising since the ECtHR has adopted a flexible and pragmatic approach to the basis upon which Convention rights are granted (eg O'Connel 2005). The next section will consider the response of the ECtHR to claims in *Pretty* which required it to address, to an extent, divergences within moral theory relevant to its recognition of and approach to the nature and constituent elements of a Convention right to enabled suicide (eg O'Connel 2005, 489).

3.3 The claims in *Pretty*

It is now over a decade since the European Court of Human Rights heard the case of Dianne Pretty, an applicant who sought to argue that her right to a suicide enabled by her husband was protected by the ECHR. Specifically, she sought to argue that the Director of Public Prosecutions (DPP) would interfere with her Convention rights if a prosecution was initiated against her husband for assisting her suicide (see further 6.6).[13] She suffered from motor neurone disease and sought to commit suicide because she wished to avoid dying by suffocation in the later stages of the disease,[14] and also to die in the familiar setting of her home. Her argument was that her claim engaged the protections of various Articles: the right to life (Article 2), the right to freedom from torture and degrading treatment (Article 3), the

[12] *Haas v Switzerland* (2011) 53 EHRR 33 para 53.
[13] *Pretty v UK* (2002) 35 EHRR 1 para 3.
[14] *Ibid* para 8.

right to respect for private life (Article 8), the right to freedom to manifest her belief (Article 9), and the right to non-discrimination in securing these rights (Article 14).

Her claim to non-interference with her husband's action fits the hypothetical "help me die" claim (1.3.3), but the fact that she sought to avoid suffering and the fact that she was dying were similar to the "end my suffering" and "let me die" claims. The following sections will examine the ECtHR's response to Pretty's claim and its response to the claims of future applicants who have advanced similar arguments. The next section will address the crucial question of what Convention *interests* applicants seeking enabled suicide are able to claim (3.4). The previous chapter considered that the adoption of a consistent sanctity of life view of the ECHR would involve ruling out enabled suicide as an interest (2.4). As is discussed below, the ECtHR has not adopted such an approach, thus leaving scope for a possible Convention right to enabled suicide on a Gewirthian conception. The equally crucial question of the *nature* of such a Convention right to enabled suicide, on the will or interest conception, is then considered (2.5). The ECtHR's decision on this point could rule out a Gewirthian approach if it was not possible to interpret the Convention right as being on the will-conception.

3.4 The object of a Convention right to enabled suicide and the sanctity of life

3.4.1 Introduction

The ECtHR in *Pretty v UK*, interpreted in Hohfeldian terms, was called to decide on whether Ms Pretty was entitled to various interests on the basis that these fell within legitimate objects of Convention rights.[15] Pretty sought to claim that her interest in enabled suicide fell within the interests set out in Articles: 2, 3, 8, 9, 14, but her argument was only equivocally successful as regards Article 8. A finding that suicide is a legitimate object of a Convention right is *prima facie* contrary to the sanctity of life view (in 2.3), since it contradicts the requirement that intentionally taking life is always impermissible. This subsection will briefly

[15] I.e. that they are within the scope of the agreed interests set out by the guarantees in the ECHR instrument which the UK was a party to.

address the basis for the ECtHR's finding that the other interests were excluded before turning to the basis for finding her interest fell within Article 8.

3.4.2 Enabled suicide found to be not within the scope of the interests in Articles 2,3,9,14

The interest in Article 2 is defined as follows: '[e]veryone's right to life shall be protected by law…. No one shall be deprived of his life intentionally'. Pretty's arguments were primarily directed towards the consistency of the ECtHR's position on the right to life and to the nature of Convention rights in general, arguments which are considered below (3.4). Specifically she argued that 'Article 2… acknowledged that it was for the individual to choose whether or not to go on living and protected her right to die to avoid inevitable suffering and indignity as the corollary of the right to life'.[16] The ECtHR referred to the consistent judgment in its case-law to the effect that the interest in Article 2 was the protection of life and made it clear that the right to life in Article 2 does not extend to a 'negative… right to die'.[17] There are multiple interpretations of this finding, some of which *prima facie* contradict the Gewirthian approach to the right to life. These interpretations are discussed as regards the nature of the right, below (3.5).

The interest in Article 3 is defined negatively: 'no one shall be subjected to torture or to inhuman or degrading treatment or punishment'. Pretty's argument was that her physical and psychological suffering as a result of her progressive terminal disease was encompassed by her negative-interest in experiencing 'degrading treatment.'[18] The ECtHR accepted that the degree of suffering was severe enough to qualify as 'degrading'[19] but found that the negative-interest in Article 3 was phrased in a way that nevertheless excluded her interest. This aspect

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[16] *Pretty v UK* (2002) 35 EHRR 1 para 35.
[17] *Ibid* paras 39-40. This could mean the intentional destruction of life generally, or, specifically, the intentional *unwilled* destruction of life (Beyleveld and Brownsword 2007, 277).
[18] *Ibid* paras 44-46.
[19] The ECtHR has defined 'inhuman' as 'intense physical or mental suffering' (eg *Kudla v Poland* (2002) 35 EHRR 11 para 92) which is qualitatively similar to the level and type of pain or degradation of capacity as for torture (a very high level of pain of either a physical or psychological nature (*Ireland v UK* (1978) 2 EHRR 25 para 167; *Valiuliene v Lithuania* (2013) (App no 33234/07) para 66), including severe degradation of physical or mental capacity (*Aksoy v Turkey* (1997) 23 EHRR 553 paras 62-3)). 'Degrading' is less definite, and extends to 'feelings of fear, anguish and inferiority… capable of humiliating and debasing' an individual, which can involve a significant degree of physical or mental pain, or effect on capacity (eg *Jalloh v Germany* (2006) EHRR 667 para 68).

of the judgment refers to the combination of Pretty's negative-interest in Article 3 (being subject to a degrading experience) with the UK government's responsibility to secure that interest (abstaining from inflicting or preventing such an experience) which is what is meant by the term 'treatment' (eg Harris *et al* 2014, 216). The implicit quality of life aspect of Pretty's claim would be rejected on a Gewirthian approach which supports the inviolability of agency; the reduced capacity for action in states of extreme suffering cannot be 'improved' by death (see 2.6.2). Therefore this aspect of the ECtHR's reasoning is defensible on that approach.

The interest in Article 9 includes '…freedom of thought, conscience and religion…' and 'to manifest his religion or belief… practice and observance.' Pretty argued that '[i]n seeking the assistance of her husband to commit suicide, [she] believed in and supported the notion of assisted suicide for herself'.[20] The ECtHR found that Pretty's beliefs and motivations did not have the quality of being a 'practice' motivated by religious or other belief, and found, furthermore, that it was not within the range of actions motivated by belief that could be covered by the Article.[21] The availability of a more suitable interest, the interest in self-determination, which it found was protected under Article 8, was significant to this aspect of the judgment.[22] This aspect of the judgment is defensible under the PGC since it is freedom of action, rather than of thought or 'belief' that is most centrally the interest affected under a Gewirthian approach to the right to enabled suicide.

Article 14 adopts a different form to the other Articles claimed by Pretty. It is set out as follows: '[t]he enjoyment of the rights and freedoms set forth in [the] Convention shall be secured without discrimination on any ground…' A preliminary point about this Article is that interpreting it as setting out a Hohfeldian interest in non-discrimination is not straightforward. The wording of the Article, which refers to the manner in which Convention rights are 'secured' by the State, appears to contradict an interpretation of Article 14 as setting forth a Convention interest that is separate from the 'primary' Convention interest claimed (Harris *et al* 2014, 788). The ECtHR has arguably interpreted the Article as creating a separate interest in non-discrimination (eg Baker 2006) but the specifics of this argument

[20] *Pretty v UK* (2002) 35 EHRR 1 para 80.
[21] *Ibid* para 82.
[22] *Ibid.*

are not relevant to this thesis. Accepting for the sake of argument that Article 14 can be interpreted as setting forth a Hohfeldian interest, Pretty's argument was as follows:

> …the effect of [the ban on assisted suicide on] her when she was so disabled that she could not end her life without assistance was discriminatory… She was prevented from exercising a right enjoyed by others who could end their lives without assistance because they were not prevented by any disability from doing so.[23]

The concept of the negative-interest of 'discrimination,' like the negative-interest in degrading treatment, cannot be separated from the State's action in securing the right (Harris *et al* 2014, 729*ff.*). It is possible to interpret the ECtHR's short response to this claim as a finding that her claim did not involve any separate negative-interest in discrimination on the basis of her disability. The ECtHR's response can also be interpreted as a finding that the near-prohibition on enabled suicide in English law did discriminate, contrary to her negative-interest in non-discrimination, but that this was justified.[24] This finding has been criticised as under-protecting Pretty's negative-interest in discrimination relative to the protections afforded in the ECtHR's case-law in other contexts (Baker 2006, 727). The analysis of discrimination in this thesis is not, however, conducted in terms of a separate possible negative-interest in discrimination (Chapter 5). Under Gewirthian theory the UK discriminates if it fails to provide a rationally defensible, proportionate and consistent restriction upon claimants' right to enabled suicide. The finding of the Court as to the Article 14 is therefore consistent with a Gewirthian analysis.

3.4.3 Enabled suicide found to be within the scope of the interest in Article 8

The interests protected by Article 8 stem from the somewhat uncertain language of 'respect for… private and family life…'. Interpreting Pretty's argument in terms of Hohfeldian interests, her argument was that self-determination is a fundamental principle of the ECHR and that 'it was Article 8 in which [that principle] was most explicitly recognised and

[23] *Ibid* para 85.
[24] *Ibid* para 88.

guaranteed'.[25] She argued that if her interest in self-determination was validly established then it logically encompassed 'decisions about one's body and what happened to it' including 'when and how to die' since 'nothing could be more intimately connected to the manner in which a person conducted her life than the manner and timing of her death.'[26] The UK government's counter-argument straightforwardly contradicted Pretty's account of a Convention interest in self-determination, arguing instead that Article 8's ambit could only extend to 'the manner in which a person conducted her life, not the manner in which she departed from it…'[27]

The ECtHR accepted Pretty's argument that self-determination was a fundamental principle of the ECHR.[28] The Court found that its previous case-law confirmed that the self-regarding decisions of people were clearly within thier Convention interest in private life, regardless of whether such decisions were harmful to their health, and that life-threatening decisions were 'arguably' also legitimately within that interest.[29] The ECtHR defended a *possible* extension of the interest in private life to self-regarding decisions that were life-terminating, such as Pretty's suicidal decision.[30] The Court agreed that respect for human freedom was fundamental to the ECHR.[31] It further sought to defend the possible extension of private life to include Pretty's decision on the basis of the existence of a domestic permission for refusal of vital treatment,[32] finding that this was equivalent to Pretty's claim (see also chapter 8). The ECtHR also based the extension of 'private life' in this way on emerging support for such a right in other Western democracies (the ECtHR referred to the Canadian decision of *Rodriguez*).[33] This finding meant that the UK was responsible for securing Pretty's right and therefore that it would need to provide a justification for the restriction of her interest (under Article 8(2)). This argument is considered in detail below (3.6). The finding that Pretty's claim could fall within the ambit of Article 8(1) was obviously a highly significant finding of principle.

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[25] *Pretty v UK* (2002) 35 EHRR 1 para 58
[26] *Ibid*.
[27] *Ibid* para 60.
[28] *Ibid* para 61.
[29] *Ibid* para 62.
[30] *Pretty v UK* (2002) 35 EHRR 1 para 58, para 67.
[31] *Ibid* para 65.
[32] *Ibid* para 64.
[33] *Ibid* para 66. *Rodriguez v. the Attorney General of Canada* [1994] 2 Law Reports of Canada 136.

In a string of recent cases following *Pretty* the ECtHR has heard applications from people in various different circumstances claiming to possess an interest in the 'manner and timing of death'. The first of these cases, *Haas v Switzerland*, concerned a suicidal applicant with severe bipolar disorder, but who was otherwise healthy.[34] His claim referred to the acquisition of the drug sodium pentobarbital, which has been widely recognised as suitable for a pain-free, rapid and certain suicide.[35] This claim is another form of "help me die" request but the applicant demonstrated less evidence of suffering than did Pretty and he was not dying (see further 1.3.3). It is only the ECtHR's statement about the scope of his interest in private life that bears on the current analysis (the alleged infringement of this right by the Swiss authorities, which the ECtHR did not accept,[36] is not relevant). The ECtHR found that:

> …the Court considers that an individual's right to decide by what means and at what point his or her life will end, provided he or she is capable of freely reaching a decision on this question and acting in consequence, is one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention.[37]

This finding confirmed unequivocally that suicidal choices fall within a principle of self-determination protected by the ECHR as part of the interest in private life. Such a finding is significant in various respects. The fact that Haas was neither dying nor faced the same quality of suffering that Pretty faced makes Haas's claim one that is closer to a straightforward request for assistance with suicide. Another notable element of this claim is the fact that he sought for the Swiss State to *act* to enable his suicide, contrasting with Pretty's claim that the DPP should refrain from interfering with her husband's enabling action. However, Swiss law differs in fundamental respects from English law and therefore any analogy that could be drawn between the responsibilities of the different regimes to secure the right to enabled suicide must be limited (see further 3.5).

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[34] *Pretty v UK* (2002) 35 EHRR 1 Para 7.
[35] *Haas v Switzerland* (2011) 53 EHRR 33 para 33.
[36] *Ibid* para 61.
[37] *Ibid* para 51.

The applicant in *Ulrich Koch v Germany*[38] also based his claim on his Article 8 interest in 'the manner and timing of death'.[39] His claim, like that in *Haas,* rested on the failure of the authorities to make sodium pentobarbital available. However, the applicant did not seek an enabled suicide for himself; rather the claim related to his wife.[40] Koch's wife suffered from total sensorimotor quadriplegia which meant that she required various burdensome treatments to continue her life (including mechanical ventilation).[41] Her circumstances were therefore, to an extent, similar to the "let me die" and "end my suffering" claims (see 1.3.3). The ECtHR resolved not to decide the merits of the wife's claim directly, but accepted that her Convention right was indirectly relevant due to Koch's 'close relation' to her and his immediate involvement in her death.[42] His complaint was that Germany had failed to secure his Convention interest since it had not put in place appropriate procedures to accept his legal standing to request merits review of the Federal Institute's refusal to authorise the acquisition by his wife of a lethal dose of sodium pentobarbital.[43] It is unnecessary to develop the analysis of Germany's responsibility to secure the Convention right in *Koch* further, as this analysis is not relevant to the thesis.[44] *Koch*'s significance arises primarily on the basis that the ECtHR confirmed the approach in *Haas* as to the relevant Convention right, and even supported a finding of a violation of Koch's right (see as regards the UK government's responsibility to secure Pretty's right below, 3.6).

The complaint of the applicant in *Gross v Switzerland*[45] was, similar to those in *Haas* and *Koch* – that her Convention interest in deciding 'when and how she would die' was being interfered with by Switzerland since she could not obtain sodium pentobarbital. The findings in the applicant's case in *Gross v Switzerland*,[46] heard by the ECtHR Second Section in 2013,[47] were undermined by the subsequent finding of the Grand Chamber[48] in 2014. The

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[38] *Ulrich Koch v Germany* (2012) (App no 497/09) judgment of 19th July 2012.
[39] *Ibid* para 76 as regards the applicant's wife.
[40] His wife could not bring the claim herself as she had died before the claim could be brought since she obtained the desired assistance in Switzerland (para 12).
[41] *Ibid* para 8.
[42] *Ibid* para 45.
[43] *Ibid* para 27.
[44] *Ibid* paras 78-82.
[45] *Gross v Switzerland* (App no 67810/10) judgment of 14th May 2013.
[46] *Gross v Switzerland* (App no 67810/10) judgment of 14th May 2013; *Gross v Switzerland* (App no 67810/10) judgment of 29th September 2014.
[47] *Gross v Switzerland* (App no 67810/10) judgment of 14th May 2013.

Grand Chamber found that her case contained two fundamental failures of fact: she was neither a subject of Convention rights at the time her case was brought (being deceased),[49] nor had she been denied the Convention interest that she claimed.[50] The approach of the Second Section nevertheless remains relevant to the current analysis, since it indicates the manner in which the ECtHR might decide such cases in future. Gross suffered from no specific medical condition, unlike the applicants in other cases;[51] she was simply elderly and desired to end her life.[52] Claims of this nature have become termed 'old age rational suicide' and are almost uniformly restricted, even in countries that permit enabled suicide on other grounds (eg SOARS 2014; CARE 2014; see further 9.4). The Second Section not only accepted Gross' interest, but used it as the basis for the finding that Switzerland had failed in its responsibility to protect her rights.[53] Gross's purported claim was a "help me die" claim without any overlap with claims to "end my suffering" or "let me die". It therefore unequivocally confirms that the Convention interest in 'private life' encompasses a Gewirthian interest in enabled suicide.

3.4.4 Enabled suicide as an object of Convention rights and the sanctity of life

The finding, in *Pretty*, that a Convention interest in enabled suicide is legitimate, and that the UK government is responsible for securing such an interest, appears to be a straightforward departure from the sanctity of life approach which is opposed to such recognition (see 2.4). This point is significant in terms of the ECHR's endorsement of the inviolability of agency position and is therefore expanded upon in this sub-section. It is submitted that the ECHR must be interpreted as rejecting the sanctity of life view, but that certain of the ECtHR's statements as regards the interest in Article 2 in *Pretty* complicate the issue.

In *Pretty* the ECtHR made the following statement about the interest in life in Article 2:

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[48] *Gross v Switzerland* (App no 67810/10) judgment of 29th September 2014.
[49] *Ibid* para 35.
[50] *Ibid* para 34.
[51] *Ibid* para 7.
[52] *Ibid*.
[53] *Ibid* para 67.

> It is unconcerned with issues to do with the quality of living or what a person chooses to do with his or her life.[54]

This statement could be taken to imply the following: firstly that life as a Convention interest is on the sanctity conception; secondly that the Convention does not define the interest in life in terms of these rival conceptions and that the UK government may therefore adopt either a sanctity of life, quality of life, or inviolability of agency conception. The first option is contradicted by other statements by the ECtHR in *Pretty* itself:

> To the extent that [quality of life and 'chosen life'] aspects are recognised as so fundamental to the human condition that they require protection from State interference, they may be reflected in the rights guaranteed by other Articles of the Convention...[55]

This statement contradicts the sanctity view of life as a Convention interest since States cannot plausibly be required to recognise that people under their jurisdiction have opposing Convention *interests*.[56] This is because, while Convention interests may require the balancing of interests against each other in order to protect them in law, if they are opposed *as Convention interests*,[57] then States would hypothetically be required to violate the Convention interests of one person in order to uphold the Convention interests of another, which is implausible (eg Letsas 2007, 15). The ECtHR later contradicted the sanctity of life conception of life as a Convention interest in Article 2 in *Haas*:

> [Article 2] obliges the national authorities to prevent an individual from taking his or her own life *if the decision has not been taken freely and with full understanding of what is involved*.[58] (my emphasis)

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[54] Para 39.
[55] Para 39.
[56] This is contrary to the ECtHR's statements that it interprets the Convention guarantees as a whole (eg *Haas v Switzerland* (2011) 53 EHRR 33 para 54).
[57] Under the Hohfeldian interpretation adopted in this thesis (2.2).
[58] *Haas v Switzerland* (2011) 53 EHRR 33 para 54.

Therefore the first possible interpretation of the ECtHR's statement in *Pretty* as an endorsement of the sanctity conception of the Convention interest in life has been decisively rejected.

The second possible interpretation of the ECtHR's statement in *Pretty* is that the *State* can define the interest in life. This interpretation is compatible with the approach in this thesis only if reasons can be given for the UK to adopt the inviolability of agency conception of life as a Convention interest. This would be the case if it could be demonstrated that a Gewirthian rights-based theory is a superior account of life as a Convention interest compared to rival quality and sanctity accounts (see further 2.4 and 2.5). A decisive basis for preferring Gewirthian theory as an account of the Convention rights could be defended by a justified principle of Convention rights as human rights; such an argument is made in chapter 4.

3.4.5 Conclusion

The interest in private life, protected under Article 8, is, so far, the only Convention interest applicable to "help me die" claims to enabled suicide. There is no confirmation as to the existence of a Convention interest in the "take my life" situation, nor the "end my suffering" or "let me die" situations. The ECtHR's approach to the interest in private life in *Haas*, *Koch* and *Gross* (in the Second Section) indicates that it is the *autonomous request* that is within the interest in private life, and neither the enabler's intention nor the state of health of the suicidal individual are significant in relation to the existence of the interest. There is no reason why the 'choice as to how and when to die' should not encompass the interest in all such claims, as the UK courts accepted in the *Purdy*[59] and *Nicklinson*[60] litigation (in which the ECtHR's judgements in *Haas*,[61] *Koch*[62] and *Gross*[63] were referred to). However, these further factors, of intention and medical condition, may be of decisive significance to the UK government's *responsibility* to secure this right. This chapter will turn to the question of responsibility to secure the right to enabled suicide shortly (3.6), but it is firstly necessary to

[59] *Purdy v DPP* [2009] UKHL 45 [39].
[60] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [55].
[61] *Haas v Switzerland* (2011) 53 EHRR 33.
[62] *Ulrich Koch v Germany* (2012) (App no 497/09) judgment of 19th July 2012.
[63] *Gross v Switzerland* (App no 67810/10) judgment of 14th May 2013.

establish the *nature* of such a right in order to determine the significance of 'exercise' 'waiver' or 'claiming' as concepts of *rights*, which, it was argued in 2.2.4, is crucially important to the characterisation of that responsibility.

3.5 The nature of the Convention right to enabled suicide

As was discussed in 2.2.4, 'exercise' 'waiver' and 'claiming' are actions by a person who possesses a Convention right which affect the respondent's duty to secure to that person the benefit of their right. It is necessary to determine that the right to enabled suicide involves waiver over the benefit of continued life, which is compatible with the Gewirthian conception. The concept of rights-waiver is associated with the legal and moral theory that the existence of a 'right' to some benefit centrally requires control over that benefit, which is termed the will-theory of rights (see 2.2.4). The will-theory of rights applied to the ECHR reflects a conception of the ECHR/UDHR's moral foundation as arising from agency or self-determination (eg Letsas 2007, 13; see further 2.2). It was well established before *Pretty* that a claimant's refusal of the benefit of Convention rights that are fundamental to his wellbeing, including the benefits of vital assistance/healthcare, must be respected.[64] However, when Pretty raised the novel argument that her Article 2 *right* to life included a *right* to die,[65] the ECtHR disagreed.[66] The ECtHR's failure to accept her argument is problematic in terms of the Gewirthian conception of the right to enabled suicide set out in 2.6, which centrally relies on a conception of the right to enabled suicide derived from the capacity for a rights-holder to waive the 'benefit' of the continuation of his life.

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[64] *Herczegfalvy v Austria* (1993) 15 EHRR 437 paras 83, 86; *Jehova's Witnesses of Moscow and Others v Russia* (2010) App no 302/02 (judgment of 10th June 2010) para 136. The Convention on Human Rights and Biomedicine (CHRB) created by the Council of Europe, which also governs the ECHR, is referred to by the ECtHR in the determination of applications raising bioethical issues; of particular relevance are those concerning consent (*MAK and RK v UK* (App no 45901/05 & 40146/06) judgment of 23rd March 2010). The CHRB requires that consent is sought from a relevant party in relation to individuals who cannot give consent (Article 6) and defends the principle of advanced refusal (Article 8).

[65] Pretty was claiming a right to assisted suicide only, but it is clear that this claim encompasses all forms of enabled suicide in 1.3.3 and is therefore referred to as a claim to enabled suicide.

[66] *Pretty v UK* (2002) 35 EHRR 1 para 42.

In *Pretty* it was found that the right to life in Article 2 does not extend to a 'negative… right to die'.[67] This finding appears to be a decisive judgment by the ECtHR that the Convention right to life is not a right on the will-theory, and that a Gewirthian approach to the Convention right to enabled suicide is therefore ruled out. It must be conceded that the Court's statement can plausibly be interpreted as a rejection of rights-waiver at least as regards the Convention right to life. In particular the ECtHR implicitly rejected Pretty's argument, raised before the House of Lords,[68] that Convention rights were generally waivable by analogy with other Convention rights that did 'imply their negative' such as the right to marry (Article 12).[69] Despite this, it is argued that *Pretty* does not rule out an interpretation of the Convention right to life that is compatible with the will-theory.

It is possible that the ECtHR's reference to the 'negative' of the Convention right to life is not equivalent to giving up the benefit of that right, as occurs with rights-waiver (see 2.2.4). The ECtHR could be taken to be rejecting the similarity between the nature of the benefit of the right to life and the right to marry in the respective Articles. In the case of the right to marry the benefit that is expressed in Article 12 is straightforwardly the status of being married, but it is not necessarily the case that the benefit claimed in Article 2 is the status of 'being alive'. The benefit of a Convention right to life in Article 2 is best described as a negative-interest in 'intentional killing'. It is plausible, as the ECtHR later implied in *Haas*,[70] that the interest in Article 2 does not encompass autonomous suicide[71] so that the negative interest in Article 2 is limited to 'intentional *unwanted* killing' (see also Beyleveld and Brownsword 2007, 273*ff*.).

If it is possible to interpret the ECtHR's statements in regard to Article 2 in *Pretty* as compatible (or at least not necessarily incompatible) with waiver of the benefit of the right to life, then it is necessary to consider the way in which this benefit could be waived. It is argued that waiver could be exercised under the Article that is most expressive of the

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[67] *Ibid* paras 39-40. This could mean the intentional destruction of life generally, or, specifically, the intentional *unwilled* destruction of life (Beyleveld and Brownsword 2007, 277).
[68] Referred to before the ECtHR in Pretty *UK* (2002) 35 EHRR 1 at para 14; *Pretty v DPP* [2001] UKHL 61 [6].
[69] Analogously with the Article 11 right to freedom of association which implies a right *not* to join an organisation *Cheall v United Kingdom* (1985) 42 DR 178, at 185.
[70] *Haas v Switzerland* (2011) 53 EHRR 33.
[71] At para 34.

principle of self-determination, which the Court accepted to be Article 8 (Beyleveld 2011, 13).[72] The protection of human life also runs throughout the Convention Articles as a whole,[73] so it is not implausible that aspects of the exercise of such a fundamental right could also find expression under Article 8. This reasoning is unorthodox,[74] but the mere fact that Article 8 sets out 'private life' as a Convention interest, while Article 2 sets out 'life' does not necessarily mean that claims under Article 8 are exclusively directed towards private life as a *separate* Convention interest to 'life'. The failure of the ECtHR in *Pretty* to state that the principle of self-determination finds its expression under Article 2(1) is not, therefore, equivalent to a finding that the principle of self-determination is irrelevant to the Convention right to life.[75] On this interpretation 'life' as the benefit of a Convention *right* to life is waivable under Article 8.

A Gewirthian interpretation of the nature of the Convention right to life remains possible after *Pretty* (see also Beyleveld 2011, 12-13) and this interpretation is further strengthened by the findings in *Haas,*[76] *Koch*[77] and *Gross*[78] (Second Section) that self-determination is central to a valid claim to a Convention right to enabled suicide. In terms of the hypothetical claims to enabled suicide it is therefore possible that S claiming a Convention interest in enabled suicide may do so by exercising his ability to waive his right to life in the "take my life," "help me die," "end my suffering" or "let me die" situations (1.3.3). This interpretation is strengthened by the fact that the statements casting doubt on the will-theory in *Pretty* were likely to be influenced by factors unrelated to theories of rights. One such factor is arguably that the judgment would have been viewed as creating a 'right to die' under Article 2, which would have represented a recognition of a strong commitment to a controversial and emergent right (eg Lewis 2007, 53-54). Furthermore, as was discussed above, Article 2 does

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[72] Pretty *UK* (2002) 35 EHRR 1 para 35.
[73] *Ibid.*
[74] The conceptualisation of this conflict is currently conceived of in terms of the ambit of the Convention rights; for example, Fenwick argues in the context of Article 5(1) that the Court avoids conflict by narrowing the ambit of the *interests* expressed in ECHR Articles (Fenwick 2010).
[75] The ECtHR was probably concerned that had it upheld Pretty's claim then the lives of vulnerable individuals would have been endangered, and Article 2(1) contains no express limitations to balance this interest in safeguarding life against the right to enabled suicide, as opposed to the limitations on the Article 8(1) right in Article 8(2).
[76] *Haas v Switzerland* (2011) 53 EHRR 33.
[77] *Ulrich Koch v Germany* (2012) (App no 497/09) judgment of 19th July 2012.
[78] *Gross v Switzerland* (App no 67810/10) judgment of 14th May 2013.

not explicitly provide that the interest in life is to be secured in a way that the State may permissibly limit by reference to the 'rights of others', unlike Article 8 (see 3.2.3).

3.6 The UK government's responsibility to secure the Convention right to enabled suicide

3.6.1 Introduction

The previous sections have demonstrated that a Gewirthian right to enabled suicide applicable to the hypothetical claims (to "take my life" etc, listed in 1.3.3) is at least a possible interpretation of the ECHR after *Pretty*. The demonstration of such a right is not, of course, conclusive as to the responsibility of the UK government to secure such a right. A Gewirthian understanding of the UK government's responsibility, fully discussed in the next chapters, is that account must be taken of the right to life of others, and the hypothetical claims may be justifiably restricted on that basis (see 4.5). This chapter will not attempt, at this stage, to set out more than an outline Gewirthian analysis of the UK government's responsibility to secure the right to enabled suicide. This section will also briefly consider the contributions of the UK courts, which have further expanded upon and defined this responsibility (a full examination of the UK courts' approach is conducted in chapter 6).

3.6.2 Legitimate grounds for the UK to deny its responsibility to secure the right

In *Pretty* it was found that there was no violation of the applicant's Convention right to enabled suicide under Article 8,[79] since the UK government's responsibility to secure her right did not include requiring the DPP to issue an assurance that he would not prosecute Pretty's husband if he helped her to commit suicide.[80] To put this finding in terms of the Hohfeldian elements discussed above, the DPP is the respondent to Pretty's claim and the UK government's alleged responsibility is to enforce his duty not to interfere with her suicide by

[79] It should be pointed out that the extent of the UK's responsibility to secure Convention rights is such as to achieve *minimal* compliance with the claimant's right, or in other words, that the Convention rights create a 'ceiling rather than a floor' (eg *R (Animal Defenders International) v Secretary of State for Culture, Media, Sport* [2008] 1 AC 1312 [53] per Lord Scott).
[80] *Pretty v UK* (2002) 35 EHRR 1 para 32.

issuing the requested assurance of non-prosecution in her husband's case. The Court's finding of no responsibility in *Pretty* is a straightforward finding that the UK government's other responsibilities prevented it from securing Pretty's right.[81] This finding and the reasoning behind it are, of course, set out in the terms of Article 8(2):

> There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of… public safety… for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

In *Pretty*, the ECtHR accepted that the DPP's alleged interference had the 'legitimate aim' of 'safeguarding life'.[82] The question of whether the interference had a basis in law was not explored in the case, although this aspect of Article 8(2) has been found to be significant in recent domestic case-law (discussed below, 3.6.3).

The primary question that the ECtHR was required to consider in *Pretty* was whether the DPP's alleged interference was 'necessary in a democratic society'.[83] Before conducting a detailed examination of the ECtHR's reasoning it is useful to briefly expand upon this concept and relate it to the Hohfeldian elements above. The 'necessary in a democratic society' analysis typically involves a two stage judgment as to whether the alleged interfering conduct is rationally necessary to meet the legitimate aim and, if it is, whether interference with the claimed right is a proportionate way of meeting that aim (eg Harris et al 2014, 505*ff.*). The ECtHR is not necessarily capable of judging the reasoning and evidence forming the requisite proportionality analysis and thus a discretion is accorded to the State which is termed the 'margin of appreciation' (Harris et al 2014, 510*ff.*; Letsas 2007, 90*ff.*). The scope of this doctrine is disputed, and is heavily influenced by the institutional limitations of international human rights law (Letsas 2007, 80*ff.*). In terms of the Hohfeldian conception the 'margin of appreciation' concept can be understood as the ECtHR's role in overseeing and

[81] Rather than on the basis of factors unrelated to the general justifiability of such conduct, such as that requiring the DPP to act in this way was impractical as too expensive etc.
[82] *Pretty v UK* (2002) 35 EHRR 1 para 69.
[83] *Ibid* para 70.

guiding the domestic proportionality judgment when it cannot arrive at such a judgment itself (Helfer and Slaughter 1997, 316-17).

The ECtHR in *Pretty* accepted the government's argument that the Court's role in overseeing proportionality would be limited, thus rejecting Pretty's suggestion that the importance of her right justified particularly close oversight.[84] The UK government argued that it was 'entitled, within its margin of appreciation, to determine the extent to which individuals could consent to the infliction of injuries on *themselves* and so was even more clearly entitled to determine whether a person could consent to being killed'.[85] The ECtHR was in agreement with the domestic courts in finding that Pretty could not be protected from *herself* as a vulnerable person.[86] This finding is in straightforward agreement with the rights-based Gewirthian conception of the UK government's responsibility to give effect to an agent's rights only insofar as so doing does not create disproportionate interference with the commensurate rights of *other* agents (discussed in 4.5).

The ECtHR also accepted that the UK government was 'entitled to regulate through the operation of the general criminal law activities which are detrimental to the life and safety of other individuals' and 'the more serious the harm involved the more heavily will weigh in the balance considerations of public health and safety against the countervailing principle of personal autonomy'.[87] The rationale of UK law prohibiting assisted suicide was considered to be the protection of the 'weak and vulnerable' and 'especially those who are not in a condition to take informed decisions against acts intended to end life or to assist in ending life.'[88] Therefore, while Pretty herself was not able to take an informed decision to end her life, it was a valid concern that if *others* could make a similar request of the DPP there was the potential for 'abuse' of such a procedure. This possibility might then lead to the insufficiently informed and 'vulnerable' suicidal individual, whom the UK was entitled to protect, committing suicide with assistance.[89]

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[84] Analogously with other cases in which this had been a factor; see *ibid* para 71.
[85] *Ibid* para 60.
[86] *Ibid* para 73.
[87] *Ibid* para 74.
[88] *Ibid.*
[89] *Ibid.*

The lack of guidance provided by the ECtHR as regards what it considers 'sufficiently' informed suicide and as to when a person is deemed 'vulnerable' has been the subject of academic criticism (eg Pedain 2003, 205-06). A Gewirthian conception of the duty, set out in chapter 5, will justify the adoption of specific criteria to determine when a suicidal decision is taken 'non-vulnerably' or, rather, competently (see 5.2-5.6). The ECtHR's lack of guidance might stem from its finding that it was for the *UK government* to assess the way in which Pretty's Convention right was to be balanced against safeguards for the 'vulnerable'. Academic commentators have criticised judgments of this type as relying on a 'substantive margin of appreciation;' they argue that such judgments undermine the action-guiding quality of the Court's jurisprudence, effectively giving a State an absolute discretion to balance a right against countervailing factors (eg Letsas 2007, 80*ff*.).[90] It is argued that the ECtHR should instead adopt a 'structural' margin of appreciation' approach to balancing, which accepts that an international court should refrain from specific, complex, often evidential judgements associated with proportionality that are properly within the competence of national courts (eg Letsas 2007, 90*ff*.). Under this 'structural' conception the UK government would have a weak discretion to balance Pretty's right against safeguards, which would be governed by Convention principles. It is argued that only this latter conception is defensible from a Gewirthian perspective (see 4.5). Overall, the finding that the UK government did not fail in its responsibility to secure Pretty's right, by requiring that the DPP issue the requested assurance, is a judgment that is *possibly* defensible in relation to a Gewirthian right to enabled suicide, but it is necessary to expand upon this analysis extensively in order to defend such a judgment, and that is the goal of the subsequent chapters.

Pretty also challenged the arbitrariness of the 'blanket ban' on assisted suicide in English law as coupled with a permission for suicide;[91] furthermore, she argued that such laws disproportionately affected her as a disabled person (under Articles 8 and 14).[92] The Court considered that the ban on assisted suicide was directed towards protecting the physically disabled and that its blanket nature was justifiable because of the risk of abuse.[93] The ECtHR also defended as non-arbitrary leniency in prosecution and sentencing of enablers despite the

[90] *Ibid* para 74.
[91] Suicide Act s1. See chapter 6.
[92] *Ibid* para 59; para 85.
[93] *Ibid* para 89.

near-absolute prohibition on assisted suicide.[94] These finding are *prima facie* contrary to a Gewirthian account for the following reasons. Firstly, the distinction between able bodied and disabled persons does not directly serve the purpose of protecting agents from committing suicide while not competent to do so voluntarily and rationally (see chapter 5). Secondly, the apparent judgment that assisting informed and voluntary suicides should not be *prosecuted* contradicts the legal judgement that a near-absolute prohibition is necessary to protect suicidal agents. A possible justification for such an apparent contradiction is that such distinctions are non-arbitrary as indirectly justifiable under the PGC (see further 4.5).

Pretty also argued that the DPP should exercise his discretion to issue an assurance of non-prosecution in Pretty's case, and her case *alone*, as an exceptional procedure. She argued that her competence had been established as a result of the court proceedings, so there was no basis to refuse her request for non-prosecution of her husband's assistance in her suicide.[95] The ECtHR rejected her argument on the basis that the blanket ban was justifiable both due to the need for safeguards and compassionate restraint upon prosecution.[96] It is submitted that the failure to endorse even a requirement that an exceptional legal procedure should be made available to claimants was an unduly limited conception of the government's responsibility, which should, at the least, amount to providing for some direct official oversight of competent suicide. In this respect the judgment in Pretty is contrary to the PGC (see further 6.7).

Overall it is implausible to find that the UK government would now be judged by the ECtHR to have failed to uphold its responsibility to secure the Convention right to enabled suicide of any of the hypothetical claimants in the "take my life," "help me die," "end my suffering" or "let me die" situations after *Pretty*. The ECtHR's judgment should be understood as an opportunity for relevant domestic authorities to take account of enabled suicide as a Convention right and conduct a more rigorous evaluation of the proportionality of English law on assisted suicide (eg Pedain 2003, 205-06). This analysis requires a proportionality judgement based on justifiable criteria that address the rational necessity of the near-absolute prohibition on assisted suicide in English law. The following chapters will seek to advance

[94] When there was evidence that their involvement in suicide was compassionate and that the suicidal individual was rational and informed (*Ibid* para 76).
[95] *Ibid* para 75.
[96] *Ibid* para 76.

such criteria and then apply them to current English law and to proposals of reform. However, before considering such Gewirthian criteria it is useful to examine the approach in domestic jurisprudence to the Convention right to enabled suicide since *Pretty* in order to develop further the legal understanding of such a right in the UK.

3.6.3 The interpretation of the UK government's responsibility by domestic courts

Pretty had first brought her claim, domestically, under the HRA, seeking, unsuccessfully, to require the DPP to act compatibly with her Convention rights (section 6).[97] Seven years after Pretty's unsuccessful application to the ECtHR, another claimant, Purdy,[98] also sought to argue that the UK government had failed in its obligations to secure her Convention right to enabled suicide under Article 8, relying on *Pretty v UK*.[99] Purdy desired to travel from the UK to commit suicide legally in the Swiss Dignitas clinic with her husband's aid.[100] Purdy did not challenge the UK in terms of its responsibility to secure her right to assisted suicide by requiring the DPP to issue an assurance that her husband would not be prosecuted, as Pretty had done. She instead sought *guidance* from the DPP as to whether her husband would be prosecuted, in her circumstances, for helping her do so.[101] Purdy's argument was arguably framed so as to avoid the appearance that she sought to create an 'exception' to the prohibition on assisted suicide (eg Mason 2009, 300-301). Her claim sought instead to demonstrate that the UK government's responsibility to uphold her right contained a *procedural* aspect; she argued that the lack of guidance as to how the DPP would exercise his discretion to prosecute her husband meant that interference with her right was not 'in accordance with the law' (Article 8(2)).[102] She argued that, without guidance, she did not have a sufficient basis upon which to judge whether the DPP would interfere in the event that

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[97] *R (Pretty) v DPP* (2001) EWHC 788 (HC). Under the HRA the English courts are empowered to interpret primary legislation compatibly with the UK's legal responsibilities to secure Convention rights where possible (s3 HRA 1998). They are furthermore empowered to issue declarations of incompatibility where such an interpretation is not possible (s4) and can require public authorities to act compatibly with Convention rights (s6).
[98] *R (Purdy) v DPP* [2009] UKHL 45 (HL).
[99] *Ibid*; see also *Pretty v UK* (2002) 35 EHRR 1.
[100] *R (Purdy) v DPP* [2009] UKHL 45 (HL).
[101] *Ibid* [3].
[102] *Ibid*.

she sought to exercise her Convention right.[103] It is unnecessary to develop the procedural elements of Purdy's claim here in detail (they are discussed further in 6.5).[104] The House of Lords accepted her arguments unanimously; they confirmed the existence of the claimed right, based on the ECtHR's reasoning in *Pretty v UK,*[105] and also found a violation.[106] The guidelines issued as a result of this judgment are considered further in chapter 6 (see 6.5.3).

Subsequently to the finding in *Purdy* the Supreme Court revisited the question of *proportionality* in *Nicklinson v Ministry of Justice*[107] (a detailed examination of these claims is made in chapter 6). The paralysed claimants in the *Nicklinson* case fitted the "take my life" as well as the "help me die" situations, and both were accepted to be within the Convention right recognised in *Pretty* and *Purdy*.[108] Among their various claims was a general challenge to the Suicide Act 1961 on the basis that it criminalised the actions of enablers and thereby interfered with their Convention right to enabled suicide.[109] The Supreme Court was called upon to decide whether to issue a declaration of incompatibility as regards s2(2) of the Suicide Act 1961 and the claimed right.[110] The Supreme Court found unanimously that the UK's margin of appreciation had not been exceeded by passing the Suicide Act.[111] However, a narrow majority accepted that even within that margin, the domestic courts were capable of balancing the interests involved and therefore a violation of the Convention right was *possible*, as chapter 6 discusses. However, the Supreme Court did not consider it appropriate to issue a declaration on the facts of the case.

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[103] *Ibid* [40]. 'The Convention principle of legality requires the court to address itself to three distinct questions. The first is whether there is a legal basis in domestic law for the restriction. The second is whether the law or rule in question is sufficiently accessible to the individual who is affected by the restriction, and sufficiently precise to enable him to understand its scope and foresee the consequences of his actions so that he can regulate his conduct without breaking the law. The third is whether, assuming that these two requirements are satisfied, it is nevertheless open to the criticism that it is being applied in a way that is arbitrary because, for example, it has been resorted to in bad faith or in a way that is not proportionate.'

[104] *Ibid* [40-43]. In outline, the ECtHR employs an expansive notion of what is in 'accordance with the law' that encompasses qualitative requirements of foreseeability and accessibility.

[105] *Pretty v UK* (2002) 35 EHRR 1.

[106] *R (Purdy) v DPP* [2009] UKHL 45 (HL).

[107] [2014] 3 WLR 200.

[108] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 at [55].

[109] *Ibid*.

[110] *Ibid* at [112].

[111] *Ibid* at [66] per Lord Neuberger, [218] per Lord Sumption, [339] per Lord Kerr.

The domestic courts have therefore adopted a tentative approach towards the Convention right to enabled suicide. The initial, purely procedural, approach in *Purdy* has been superseded by the possibility of substantive protection for the claimed right. However, as will be argued in chapter 6, the equivocations over the content and nature of the UK government's responsibility described in this chapter has, to an extent, undermined the *Nicklinson* judgment. The next chapter will seek to remedy this deficiency by arguing for a Gewirthian right to enabled suicide. The reasoning and outcome of the *Nicklinson* judgment will then be examined in full and evaluated by reference to such a right.

3.7 Conclusion

The nature and constituent elements of a Convention right to enabled suicide as applicable to the "let me die" and other hypothetical claims are clearly open to various interpretations. The equivocations over nature and object of the right to enabled suicide explored in this chapter mean that the ECHR is capable of being interpreted in accordance with various moral positions that are prominent in Western thought concerning the justifiability of such a right (see 2.5). The lack of moral resolution is unsurprising, since the ECHR does not embrace or reject any of these broad camps in so far as they all support the protection of 'human rights' for those within the jurisdiction of European signatories (eg O'Connell 2005, 487; Letsas 2007, 21*ff.*). However, such a position undermines the practical effect in English law of a Convention right to enabled suicide that is interpreted solely by reference to the ECHR text, since it supports a diffuse conception of the UK government's responsibility to balance the right against other interests. A Gewirthian interpretation of the right to enabled suicide will seek to defend principles of proportionality to govern the UK's responsibility to conduct such a balancing exercise. The justification for adopting such an interpretation is advanced in the next chapter.

Chapter 4: The PGC as a justification for the existence and nature of a human right to enabled suicide

4.1 Introduction

The interpretation of the UK's obligation to secure the Convention right to enabled suicide of the hypothetical claimants ("take my life etc in 1.3.3) requires defence if it is to be preferred as against rival moral positions. This chapter will seek to demonstrate that the Gewirthian supreme principle of morality and human rights, the principle of generic consistency (PGC), has a strong claim to acceptance as an ethically rational principle justifying Convention rights as the generic rights of agents. In order to do so it will be demonstrated that the Gewirthian approach based on agency creates the possibility for a morally objective approach to the justification of the Convention rights, which encompasses a fully developed conception of the UK's responsibility to secure claimants' *generic* right to enabled suicide.

This chapter offers an outline of the Gewirthian dialectical method as an ethically objective approach that is capable of defending the PGC as a supreme moral principle of human rights (4.2). The connection between the PGC and human rights as practically effective rights for all humans is then defended from criticisms of its premise (4.3). The constituent elements of a Convention right to enabled suicide as a generic right of agency, first set out in chapter 2 (see 2.6) are reconsidered in light of the dialectical approach (4.4). Finally the chapter sets out the basic principles of a Gewirthian evaluation of English law in terms of the generic right to enabled suicide (4.5). In order to break down and clarify this analysis the various applications of the PGC will be set out and compared with familiar concepts of (moral/legal) rights-based evaluation such as 'violation,' proportionality and 'margin of appreciation' as discussed in the previous chapter (3.6).

4.2 A dialectical justification for the Principle of Generic Consistency

4.2.1 Introduction

It is necessary to provide reasons for preferring one set of moral criteria justifying a single approach to the right to enabled suicide despite the established divergences between the moral theories of human rights considered in chapter 2. Moral theorists within each of the camps have, of course, sought to provide such reasons, but it is unnecessary to recount every attempt. An ideal justificatory strategy is one that can provide good reasons to identify the basis upon which all agents are granted moral status (Gewirth 1978, 3).[1] This strategy of justification would be capable of providing reasons for adopting the moral point of view itself, and of providing a purely rational justification for the existence of moral human rights in general. This thesis argues that the strategy adopted by Gewirth, of a necessary moral proposition by agents derived from agency in a dialectic, is capable of establishing such a justification (Gewirth 1978, 42*ff*.; Beyleveld 1991, 21*ff*.). The strategy ultimately adopted in this thesis is not, in fact, the full dialectically necessary method, but, rather, its application to agents *who accept human rights norms*. This is in order to build acceptance for Gewirthian theory, the full extent of which is extremely controversial.

4.2.2 Ethical rationalism and the idea of a supreme principle of human rights

A supreme principle of human rights requires it to be demonstrated that Gewirthian moral criteria are ones that all rational agents should adopt; however, few ethicists now accept that it is possible to demonstrate such rational necessity. Instead modern ethicists tend to agree that a justification entirely from a logical/empirical basis is impossible (eg Glover 1977, 35; Singer 1993, chapter 1; Harris 1993, 8-9), and seek to rationalise from commonly accepted moral positions. One strategy, common within rights-based theory, is to rely on widely accepted intuitions about the fundamental rights that humans possess, so that evaluation of moral criteria is limited to demonstrating that a particular criterion is logically consistent with these 'self-evident' intuitions (Nozick 1974; Dworkin 1977, 15). This is not the approach that is adopted in this thesis.

[1] Relativist human rights ethicists argue that human rights are not moral rights at all, but rather standards that guide religious/cultural norms in signatory states (see eg Chwaszcza 2010). A justificatory strategy that seeks to use logic to defend one conception of morality is one that is morally objectivist.

Gewirth (1978) and Gauthier are rare examples of theorists who have attempted to provide an account of morality that is entirely derived from logical analysis of human interests and reason. Gauthier's approach, which is prudential, is to argue that moral[2] criteria are created by purely rational constraints on an individual's pursuit of self-interest in favour of others within communities, in order for him to maximise that interest (Gauthier 1986, chapter 1). However, Gauthier's theory was not directed towards establishing categorical moral requirements (eg Pattinson 2014, 16-021). Furthermore, there is agreement among moral theorists that his approach contains a flaw: Gauthier's theory assumes a bias towards truth-telling that is not provided for by the non-moral premise of rational self-interest (see eg Moore 1994, 216).

Gewirth's rights-based approach, meanwhile, seeks to defend a supreme principle of morality and human rights from the fact of agency. Unlike Gauthier, Gewirth's theory seeks to establish a categorically binding moral principle, the Principle of Generic Consistency, or PGC (Gewirth 1978, 135). Gewirth's approach has detractors, but no decisive objection has been raised (see Beyleveld 1991, 360*ff*.). A further argument for the acceptance of this supreme principle has been advanced from the fact of agency and the premise that humans are equal in dignity and rights (Beyleveld 2011). In particular, this argument finds that human rights must fundamentally require agents to recognise that other agents should be treated with equal concern and respect (Beyleveld 2011, 3). If this latter theory is correct, then agents who accept the premise of human rights, and the existence of their agency, would be rationally required to interpret the moral requirements of human rights as rationally defensible under the PGC. The Principle of Generic Consistency and Beyleveld's arguments for it are set out below.

4.2.3 The dialectically necessary method and the PGC

Gewirth argues that human rights must be granted to the conditions of action according to a principle by which they are granted on the basis of the equal claim of all agents[3] to these conditions under the PGC. Agency is viewed as capable of providing the justification for

[2] Adopting a definition of morality as 'other-regarding' and prescriptive.
[3] The definition of an agent is set out in the introduction (1.2.4).

morality on the basis of the expansive conception of the needs of agency that Gewirth adopts, which encompasses not only non-interference with the free action of the agent, but also the capacity for the agent to act. Gewirth argues that an 'agent,' a rational being capable of acting to further its purposes, reasoning from its internal viewpoint, would deny its agency (be inconsistent) if it failed to recognise that it practically and morally ought to accept the claims of all agents to possess the generic conditions necessary for agency (this is the PGC). This reasoning takes the form of a hypothetical dialogue from the perspective of the claims of an individual agent, and is therefore dialectical.

Gewirth's theory is that a supreme moral criterion will emerge from consideration of agency by an agent within a *logically necessary* hypothetical dialectic that the agent must participate in as an agent seeking to act according to reason. This is therefore a 'dialectically *necessary* argument' since the claim by the agent to be an agent is required on the basis that it would be logically inconsistent to reject that claim. The steps of the argument similarly 'proceed inevitably, because they employ only purely logical principles' or are similarly adduced by reflection on being an agent (Beyleveld 1996, 15). This rational requirement of non-contradiction moves from an internal perspective of an agent to the internal perspective of every agent by logical consistency. The entire sequence, if successful, avoids contingent assumptions about morality or agency; it advances purely by formal logic and therefore must be fundamental to any position that is grounded on rationality. The dialectically necessary argument, if successful, would establish the PGC as a Kantian categorical principle 'connected (entirely *a priori*) with the concept of the will of a rational being as such' (Kant 1785 (trans. Paton 1948), 106; Beyleveld and Brownsword 2001, 88*f*.).

The first steps of the argument involve a self-regarding agent 'considering' the necessary implications of his status as an agent for his needs as an agent. The following summary relies upon Beyleveld's summary of the same principle in 'Dialectically Contingent Justifications for the Principle of Generic Consistency and Legal Theory' (Beyleveld 1996, 15). (The claims of the agent are put in quotation marks to convey the notion of a dialogue.)

<u>Stage One</u>

In the first stage of the argument the agent rationally reflects on his agency and the needs that flow from it.

If I claim:
(1) "I am an agent,"

I also must claim:
(1a) "I do X voluntarily from purpose E that I have chosen,"
(2) "E is good."

There are:
(3) Generic Conditions of Agency (GCAs).[4]

I must (dialectically) necessarily claim that:
(4) "Possessing these GCAs is good for my purposes"; that is:
(4a) "categorically instrumentally good"; that is:
(4b) "a necessary good."

Stage Two

In the second stage the agent, building on his reflection on the needs of its agency in the first stage, realises that it should be motivated to act to pursue the generic conditions.

If I value the GCAs as in (4):
(5) "I categorically instrumentally ought to pursue/defend my having the generic conditions."[5]

[4] These conditions are termed *generic* needs of agency, as opposed to specific needs, because they are necessarily generic, being needs that an agent has by virtue of being an agent.
[5] As a *rational* agent it is only coherent to recognise 'oughts' that are possible, and it would not be possible for an agent to pursue/defend its generic conditions if *other agents* interfered with its possession of the generic conditions.

(6) "Other agents categorically ought not to interfere with my having the generic conditions / ought to aid me to secure the generic conditions, if I so wish." [6]

(7) "I have *rights* to the generic conditions."

Stage Three

In the third stage it is shown that the agent, understanding the (dialectically) necessary implications of the previous two stages, must grant rights to the generic conditions to other agents.

If I have rights to the GCAs on the basis that I value them as an agent:[7]
(8) "I must consider that my agency is a sufficient reason to have a right to the GCAs, or contradict that I have the generic rights and am an agent."[8]

(9) "I must consider other *agents* to have rights to the generic conditions."

Because these claims are claims of *any* agent:
(10) Other agents therefore have a right to the generic conditions.

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[6] In other words, from the internal perspective of the agent the claim 'other agents ought not to interfere with my possession of the generic conditions' is justified. It is important to note at this stage that the necessary defence of the generic requirements of agency does not mean that an agent cannot (without self-contradiction) have as its purpose a result that will diminish or end its agency. Its decision must be voluntary because it need only value its possession of the generic conditions of action (GCA) categorically *instrumentally*.

[7] And if the previous stages are correct.

[8] This is termed the argument from the sufficiency of agency (ASA). In outline because the grounds for claiming my (7) is *my agency* by the principle of logical universalisability (Gewirth 1978: 105) I must recognise that agency is a sufficient ground for claiming (7), so that in this case all *others* with the property of being agents must logically have rights to the generic conditions. Logical universalisability dictates that where a predicate belongs to a subject *due to having a property*, so all beings with that property must be taken similarly to have the predicate, or contradict that having the property is a sufficient reason. Scheuermann, and subsequently Chitty, have argued that the implication of the ASA ((7) above) is not that an agent would regard agency positively in general, but rather its *own* agency (Scheuermann 1987; Chitty 2008), and as a result that 'claiming on the basis of my agency' does not involve the agent in self-contradiction if it does not then grant the generic rights to others. This objection is disputed by Beyleveld who has argued that it fails to appreciate that the agent claims the generic rights on the basis of its understanding that it is a being within a class of beings capable of valuing its purposes, which basis it would deny were it not to grant the generic rights to other agents (Beyleveld 1991, 288*f.*; 2009).

(11) All agents have rights to the generic conditions, which they can claim against each other; this is the PGC.

The second and third stages of the dialectically contingent argument have been broadly objected to by moral philosophers although no decisive objection has emerged (Beyleveld 1991, 363*ff*.) and the implications of the argument as a justificatory criterion for human rights is not widely accepted in human rights theory. A prevalent trend in modern ethical approaches to human rights is to emphasise the importance of compromise between rival moral approaches and to seek to justify broad conceptions of 'human rights' and avoid the 'hard objectivist' approach attempted by Gewirth (eg Chwaszcza 2010). A prevalent criticism of stages two and three is the now widely accepted view that human interests alone are incapable of justifying human *rights* to those interests (eg Beyleveld 1991, 92*ff*, 257*ff*., 364). It is unnecessary to consider these criticisms, or the detailed rebuttals of them, in this thesis,[9] due to the adoption of a contingent argument based on human rights. The contingent method advanced below instead relies on the less controversial first stage of the dialectically necessary argument.

4.2.4 Human rights and the dialectically contingent argument for the PGC

This thesis does not seek to mount a defence of the dialectically necessary argument for the PGC from agency alone and seeks to gain acceptance by its necessary application to human rights. The PGC is intimately connected with the concept of human rights (eg Gewirth 1996, 16-20) and in *Reason and Morality* and in the *Community of Rights*, Gewirth identifies the importance of meeting the strict oughts within human rights (as claim-rights) with a sufficient justificatory criterion (Gewirth 1978, 8-12). This section therefore sets forth a dialectical justification that is not entirely 'necessary', as it contains the contingent assumption of this thesis that human rights are valid as Hohfeldian personally oriented requirements justifiable for all human persons (see 2.2). In other words, the agent's acceptance of the PGC under this argument is dialectically *contingent* since it relies on an assumption by the agent that human rights are valid in this way. This assumption is merely contingent, rather than necessary,

[9] Deryck Beyleveld sets out a comprehensive list of objections (and defences) of Stage II of the dialectically necessary method in *The Dialectical Necessity of Morality* (Beyleveld 1991, chapters 5-7).

since it does not stem from logically necessary reflections by the agent on its agency. In this form of the argument for the PGC, the agent, having made its assumption, reflects on the implications of holding both its agency and its assumption to be true within the dialectic.

Before setting out the dialectically contingent argument it is useful to elaborate upon this thesis's premise that human rights are valid in order to set out the relationship it has to the PGC (see 2.2). The thesis assumes that a justificatory criterion must exist that is capable of finding a reason why all humans are entitled to be treated as equal in dignity and rights. From the perspective of an agent within the dialectic, the property of humans that is relevant is their agency (thus avoiding the ontological difficulty created by 'humanity' as a basis of rights (Gewirth 1978, 100; Beyleveld 1991, 153*ff*.)). It is from this position that the commitments of conventional human rights treaties such as the ECHR should be interpreted. The foundation to the modern project of human rights as practically effective rights, the Universal Declaration on Human Rights, protects the 'equal in inherent dignity and inalienable rights' of humans (UDHR Art 1). To an agent within the dialectical method, this guarantee is interpreted as applying to agents who possess equal and inherent dignity *as agents*. The contingent assumption that human rights are valid made by an agent on the basis of his agency reveals a reason why any agent involved in interpreting or applying laws that purport to uphold human rights should adopt the PGC as a necessary tool to interpret the content and nature of human rights requirements. This is why the contingent argument is capable of justifying the PGC as a supreme principle of human rights. A failure to recognise the PGC as the supreme principle of human rights in a purported application of an ECHR right as a human right thus renders that application a failure as an ethically rational application of human rights (Beyleveld 2011, 17).

The following exposition relies heavily upon Beyleveld's argument in 'The Principle of Generic Consistency as the Supreme Principle of Human Rights' (2011). The first stage of this dialectically contingent argument is the same as for the dialectically necessary argument: that it is dialectically necessary that an agent views the generic conditions of agency as necessary goods (set out above). The second stage of this argument, however, differs in that the agent makes a contingent assumption that human rights are valid. The third stage of this argument demonstrates that the agent is committed to the PGC.

Stage 1

Adopting the dialectically necessary premise that I view the generic conditions to be necessary goods (this is stage 1 of the dialectically necessary method above ending with 4(b)).

Stage 2

And I claim that:
(5) "I think that all agents categorically ought to be treated with equal concern and respect and that it is categorically prohibited for any agent to privilege any agent over any other with regard to their possession of the generic conditions." [10]

Stage 3

It follows that in order for me to avoid both contradicting my agency and avoid contradicting my (5) I claim that:
(6) "I categorically instrumentally ought to defend other agents' possession of the generic conditions."
(7a) "All other agents categorically ought to act to defend each other's generic conditions."
(7b) "All other agents possess rights to the generic conditions."
(8) "All agents, including myself (on the basis of my (5)), have rights to the generic conditions; this is the PGC".

Therefore it follows, if stage 1 of the dialectically necessary argument is valid, and if agency is considered sufficient to claim-rights to the GCAs,[11] that it is dialectically necessary for agents who also (contingently) accept the foundational premise of the ECHR to accept that

[10] This claim assumes the validity of human rights. The claim is that there are binding categorical oughts on 'humans' is close to being the PGC minus the dialectically necessary implications of agency.
[11] Due to the radical conclusion of the dialectically necessary method there is a great deal of academic scepticism as to the soundness of the argument, and the consensus is that the argument contains a flaw, but there is no consensus as to what that flaw is (see further, Beyleveld 1991).

human rights requirements must be consistent with the PGC. It is therefore necessary to demonstrate that Stage 1 is valid, and defend the argument from various objections to its first stage.

4.3 Defence of Stage 1 of the dialectically necessary method, as relevant to the dialectically contingent method

4.3.1 Introduction

The success of the contingent method relies on the success of stage 1 of the dialectically necessary method. This stage is widely accepted, but not uniformly so. The key criticisms will be set out below, referring to the aspect of the first stage of the dialectic that is objected to. The discussion relies heavily on Beyleveld's discussion of key criticisms and his defence of Stage 1 in *The Dialectical Necessity of Morality* (1991).

4.3.2 (1) "I am an agent," (1a) "I do X voluntarily from purpose E that I have chosen," (2) "E is good."

Is action, and thus agency, a plausible starting point for a fundamental moral principle? One objection is that action cannot be fundamental as a moral principle, because it is not generic to human existence as Gewirth claims it is; rather, it is some other facet, such as living which should be considered to be fundamental (Den Uyl 1975). However, 'living,' though clearly of value to most people, does not necessarily provide the basis for evaluation of what is a foundational moral concept; when morality is understood in terms of practical precepts directing behaviour, such as human rights, then what is fundamental is what is logically necessary for agents to take into account if they are to respond to practical precepts such as human rights (Beyleveld 1991, 67). An alternative objection is that practical precepts, such as human rights, need not direct behaviour; this definition of practical precepts was inherent in the definition of morality in 2.2, but this was a stipulative definition at that stage and does not demonstrate that it is logically necessary to regard human rights (as moral precepts) as directing behaviour. However, this argument denies the premise of an agent who can ask the question "what purposes must I rationally choose to pursue?" Beyleveld elaborates on this as follows:

> Within the context of the question guiding his enterprise, Gewirth's definitions of agency and related concepts are not arbitrary, but logically necessary. Now, although there are various metaphysical theses, like determinism, which might disqualify this enterprise, unless these metaphysical theses can be proven, their "logical possibility" merely places limits on Gewirth's argument, which render its possible validity "transcendental" rather than "transcendent" in the way in which Kant intended this distinction. (Beyleveld 1991, 68)

Therefore the dialectically necessary nature of the Gewirthian starting point of agency and valuing means that it is for the contradicting thesis to prove that an agent must, logically necessarily, adopt another view of moral precepts.

Another objection is that even if action is a valid starting point for a fundamental principle of morality, the assumption that it is 'voluntary' is false. This argument rejects the supposition that it is possible for a person to choose to act freely for a reason by reference to some process that is 'internal'. On this view there are no agents and therefore it is illogical for a person to make the statement "I am an agent". The ability to evidence another mind empirically with the capacity for voluntariness is questionable (Beyleveld and Pattinson 2000, 41*ff.*; see further 5.2); however, questions as to the empirically demonstrable existence of voluntary purposiveness does not affect the dialectically necessary statement "*I* am an agent" (I possess human/generic rights), but rather denies that it can be demonstrated to an agent that *other* agents exist (others possess human/generic rights; see Beyleveld 2011, 9-10).

Finally, objections have been raised as to the claim that an agent must, logically necessarily, regard his purposes as good. One objection is that an agent may not value his purposes if he is acting to fulfil a gratuitously self-harming purpose; for example, addiction (Bond 1980, 43-44). However, such behaviours are not controlled by an agent's unforced choice and therefore are not actions of the agent. It may further be objected that the agent's choice is not entirely forced, but still the result of a powerful inclination or appetite, but, as Gewirth has observed, in this circumstance the agent who is choosing to fulfil the appetite must regard doing so as having value (1980, 140). The crucial point is that *voluntary* action upon a desire necessarily involves a commitment to judge it positively. This judgement holds even if, taking other

criteria into account, the agent ultimately regards the course of conduct he has pursued as one he ought not to have taken (Beyleveld 1991, 70).

4.3.3 There are: (3) Generic Conditions of Agency (GCAs) so I must (dialectically) necessarily claim that: (4) "Possessing these GCAs is good for my purposes"; that is: (4a) "categorically instrumentally good"; that is: (4b) "a necessary good."

There are various objections to the necessity of a human agent regarding the GCAs as necessary goods on the basis that it is possible to possess a self-destructive purpose (Bond 1980, 47-8). However, this is a misunderstanding of the nature of the value that is necessarily accorded by the agent to his purposes. An agent does not necessarily value his agency as good or bad in general, but merely as a *means* to his purpose. Therefore, if an agent purposes to commit suicide he remains committed to the GCAs despite the fact that his end is self-destructive (Beyleveld 1991, 77). This is vital to the plausibility of a right to enabled suicide under the PGC.

An alternative objection is that it is impossible to specify the nature of *generic* conditions of action in real terms since agents have vastly differing levels of wellbeing/freedom to fulfil their purposes when compared with each other and compared throughout an agent's lifespan (Narveson 1980, 659). However, the GCAs are not valued in terms of a particular experience of wellbeing/freedom, but as a generic dispositional valuing of purposes which is directed towards particular experiences of wellbeing/freedom associated with the purpose (Beyleveld 1991, 86). In other words, in Gewirthian terms the relevant valuing of the GCAs is the valuing of the *capacity* to have purposes, rather than the particular experiences of purposes and the freedom associated with such a purpose. The fact that the particular experiences of a human agent differ throughout his lifespan is irrelevant for the identification of freedom/wellbeing that is instrumental to purposing.

A related objection is that generic conditions of agency cannot be empirically known and therefore that they are not capable of being used to guide action (Brooks 1981, 293). This objection clearly overstates its case, since many facets of the existence of a human agent which are externally manifested are also generic conditions of action/purposing, even if it is conceded that the internal will cannot be empirically demonstrated. Straightforward examples

of such facets of existence include GCAs that are necessary for our existing at all, or capable of fulfilling even very basic purposes, such as the externally manifested biological processes that are associated with the existence of the mind (Beyleveld 1991, 88-89).

4.3.4 Conclusion

There is no decisive objection to stage 1 of the dialectically necessary method above (see 4.2). Therefore the interpretation of human rights as premised on agency under the dialectically contingent method should be accepted as valid. The various facets of human *development* and continuation of agency, such as 'vital signs,' considered to be significant under duty-based theory should therefore be rejected. This is particularly significant for the human right to enabled suicide under the PGC since the *current* disposition of an agent towards his fundamental interests is crucial to the justifiability of his suicide;[12] arguments that a person has a near-absolute duty to themselves to continue living, as under the sanctity of life view, are therefore comprehensively rejected on that basis. The implications of the dialectically contingent method advanced above in terms of the Hohfeldian elements and nature of a human right to enabled suicide are considered below.

4.4 The human right to enabled suicide as a generic right under the PGC

It has already been established that a Gewirthian generic right to enabled suicide establishes that the claimant and respondents of such a right are *agents* and this conception is, of course, derived from the PGC. Similarly, the object and nature of a generic right to enabled suicide, briefly set out in chapter 2 (see 2.6), are derived from the PGC. In terms of the object, generic rights are to generic conditions of action of agents (GCAs), which are established under stage 1 of the dialectically necessary method (DNM) and dialectically contingent method (DCM). In terms of their nature, the generic rights are on the will-conception because they are possessed *instrumentally* by each agent to further their own purposes. The basic constituent elements and nature of a generic right to enabled suicide is developed in this section, while

[12] Gewirth argues that self-regarding duties are valid under the PGC, but not the duty to continue one's life that is similar to the duty to refrain from taking the life of others defended under the sanctity of life view (Gewirth 1998, 134*ff*.).

the next section will develop the responsibility of UK State institutions to secure the generic right to enabled suicide.

As regards the object of a purported right to enabled suicide, the UK government must secure the generic right to life by interfering where an agent (A) acts to end another agent's (B's) life without his consent, since this destroys B's capacity for action. It is clear that involvement in life-terminating action[13] is impermissible only when such an action contradicts agent B's purposes. In *Reason and Morality,* Gewirth identified various categories of needs which are based on the degree to which certain properties are necessary for an agent to act successfully (1978, 53*ff*.). Gewirth also identified two distinct elements within each category: those properties that relate to the freedom to carry out their purpose, and those properties which relate to their wellbeing (or ability) necessary to carry out a purpose. However, this thesis is concerned with the unusual instance in which an agent has a suicidal purpose, thus, in a sense, pitting wellbeing against freedom (Gewirth 1978, 137-78). Since the PGC grants rights to the GCAs, and 'death' cannot be said to be an object of a Generic Right, then the *object* of such a right is exclusively *control* over the continuation of agency.

The fact that death is not a GCA does not deny the possibility of a 'right to enabled suicide' under the PGC since the nature of the generic rights on the will-conception imply non-interference with another agent's control over his generic right to wellbeing. It is clear that rights granted to agents under the PGC do not require of the duty bearer that the rights-holder's enjoyment of the GCAs be preserved against his will. The right to suicide is therefore implied by protection of the generic right to life, which is inherently capable of waiver (see also 2.2.4).[14] It should be emphasised that waiver will not necessarily amount to the opposite of the generic right to life, or a generic right 'to die,' that is similar in structure to the generic right to life. The generic right to life is a claim by an agent against others that they should not interfere with the continuation of his agency without his consent. This is the typical formulation of the generic right to life. The opposite of this – a generic right 'to die' –

[13] See further 5.4.2.

[14] It should be noted that despite the foundation of rights under the PGC being necessarily on the will conception, one application of the principle of precaution is to grant interest-based rights to possible agents depending on their degree of agency (Beyleveld and Pattinson 2000).

as a right that other agents should interfere with the continuation of his agency *without his consent* is nonsensical (Beyleveld and Brownsword 2007, 277). The Gewirthian approach to a right to enabled suicide is that an agent's choice as to when and how his agency should end must be respected by respondents. The freedom-oriented nature of the right to commit suicide means that any action that might be required to *enable* suicide under such a right is confined to enabling freely chosen suicide, rather than enabling death. The relevant harm caused to the suicidal agent by denying suicide is not continued life but frustration of his interest in freedom, which is protected inherently by the PGC on the DCM (Beyleveld and Brownsword 2007, 277*ff*.).

The questions of the object and nature of a Convention right to enabled suicide, which the European Court of Human Rights struggled to address in *Pretty v UK*[15] are thus straightforward under the PGC. The self-destructive aspect of a right to enabled suicide is not a cause for interest-based concerns with the protection of suicidal people, such as Pretty, from 'themselves'. However, as the next section will demonstrate, the *application* of this right to evaluate English law is not without nuance. The responsibility of the UK legislature to secure the generic right to enabled suicide by positing rules applicable to *all* agents under its jurisdiction means that there is a need to protect the generic rights of agents other than the suicidal claimant. The justifiability of restrictions on the exercise of the right to enabled suicide on the basis of the countervailing responsibility to other agent raises similar questions of proportionality, discrimination and lawfulness that were faced by the ECtHR in *Pretty* (see 3.6).

4.5 The responsibility to secure the generic right to enabled suicide in English law under the PGC

4.5.1 Introduction

The hypothetical claimants in the "take my life," "help me die," "end my suffering" and "let me die" situations (in 1.3.3) requesting assisted suicide must argue that English law has

[15] (2002) 35 EHRR 1; chapter 3 (see 3.3-3.5).

'violated' their generic right to enabled suicide if they are to claim that the English legislature and courts are required to alter English law to secure their right. The fundamental principles governing the UK's responsibility to secure the generic right to enabled suicide in law are determined by the direct and indirect applications of the PGC. A preliminary point is that securing the generic right in this context refers to a minimal requirement to comply with the PGC; this is appropriate due to the current near-absolute prohibition on enabled suicide in English law (discussed in chapters 6-8) and the complexity of variables that a permissive legal regime would have to account for.[16] The conception of 'violation' adopted, of failure to adhere to minimal requirements to secure the generic rights, is thus equivalent to the conception of a violation of a Convention right (see 2.6). Where English law does not justify an interference by State officials with a claimant's right then this represents a failure to secure the generic rights 'according to law'. This analysis captures the procedural rationale of the ECHR developed by UK courts in the *Purdy* jurisprudence; this thesis sets out this legalistic argument in outline below (4.5.4). However, the primary focus of the thesis is on the direct and indirect applications of the PGC to structure the *proportionality* analysis in *Pretty*, which remains undeveloped by the ECtHR and by UK courts.

4.5.2 Direct application of the PGC

A direct, or 'in principle' application of the PGC requires that norms posited for law must at the very least not require interference with agents' generic rights, as English law does currently in relation to most forms of enabled suicide (see further chapters 6-8). It would therefore appear that the UK courts and legislature are straightforwardly required to remove laws that proscribe enabled suicide. However, Gewirthian theory, unlike libertarian 'patient-based' deontologies (Alexander 2012), explicitly recognises that our rights may be justifiably limited by the State's capacity to secure the generic rights of *others* (Gewirth 1978, 67-68). It is at least possible that, were English law to prescribe non-interference with the rights of the hypothetical claimants, others would seek to take advantage of such a legal permission and this would raise the possibility of exposing them to pressured or depressed suicide (Beyleveld

[16] Gewirth does not accept that the generic rights should be understood as minimal rights (Gewirth 1978, 135*ff.*), but it is useful for the sake of concise presentation of the argument to adopt this convention of rights-based evaluation.

and Brownsword 2007, 294). It is therefore necessary to evaluate this possibility in terms of the PGC and consider whether it could justify prohibition of enabled suicide.

The demonstration that English law violates the hypothetical claimants' rights requires an assessment of the relevant variables in Gewirthian terms. The risk of unwanted killing, or unwanted assistance in killing, that is possibly created by pressured or depressed suicide is a risk to the generic right to life of others. While the generic right to enabled suicide is based upon a fundamental commitment to freedom of agency, as has been established above (see 4.4), the generic right to life is a 'basic good' of agency, since it is foundational for action (see 4.4). An initial point about these rights is that it is a great deal more straightforward to establish a violation of the generic right to life than it is to establish the generic right to enabled suicide, since violation of the former occurs where an agent has been killed and there is no evidence that he consented to that action (eg armed police shooting a civilian), while violation of the latter occurs where there is evidence that an agent has chosen to end his life and he cannot reasonably do so in the way he has chosen without assistance. If an agent is, reasonably, physically capable of fulfilling their suicidal purpose in another way but prefers a safe or efficacious suicide, this will not necessarily amount to a frustration of his purpose. Thus, the applicants in *Haas,*[17] *Koch*[18] and *Gross*[19] could not straightforwardly argue that a Gewirthian right to enabled suicide would prioritise their preferred form of suicide on the basis that it was in their interests to die in this way.[20] On the other hand, the proscription of a chosen form of suicide and mere availability of another form of suicide that a claimant had reason to reject because the timing and/or manner of death was sufficiently contrary to his purpose, remains a frustration of that purpose.

It is necessary to defend a reasonable balance between securing the right to enabled suicide and reasonably restricting its unsafe exercise in a way that respects the fundamental freedoms and interests involved. It is in this sense that the 'necessary in a democratic society' analysis in *Pretty* should be understood under the generic right to enabled suicide (see 3.6). If English

[17] *Haas v Switzerland* (2011) 53 EHRR 33. See 3.4.3.
[18] *Ulrich Koch v Germany* (2012) (App no 497/09) judgment of 19th July 2012.
[19] *Gross v Switzerland* (App no 67810/10) judgment of 14th May 2013.
[20] Taking into account non-commensurate interests greatly increase the complexity of the judgements required (see, for an example in a different context, Pattinson 2002a, 68*ff*.).

law is to provide for safe exercise of such a right by the claimants then there must be a process by which unsafe exercises of the rights by others is sufficiently minimised. A substantive analysis of these variables cannot be advanced beyond a basic level in this thesis due to the range of relevant variables. It is possible to avoid contested variables by conducting an evaluation of English laws in terms of rational consistency, such as Pretty's argument that English law was irrational and discriminatory in her case.[21] The lack of rational consistency of English law as regards the hypothetical claims to enabled suicide is *prima facie* a straightforward violation of the generic rights, as will be discussed in chapters 6-8.

The UK's responsibility under the generic right to enabled suicide and the Convention right in *Pretty* are similar. In order to permit safe enabled suicide for the hypothetical claimants it is necessary to enact laws that create limitations and safeguards. The capacity of relevant UK institutions to enforce such safeguards effectively is therefore crucial to any finding that English law violates the generic right to enabled suicide (this argument was central to the recent *Nicklinson* litigation, see 6.7).[22] Beyleveld and Brownsword sum up the balance between non-interference in the exercise of enabled suicide and the necessity of safeguards as follows (2007, 297):

> …the State will need to demonstrate that its prohibition is a necessary and proportionate measure appropriately related to the protection of rights…of fellow agents…

If such safeguards are judged to be sufficiently achievable then failure to put them in place and merely rely on prohibition is a failure of the UK's responsibility to act to secure the right to enabled suicide. This is the basis for a *prima facie* proportionality judgement in principle; the specific variables informing such a judgement are considered in chapter 5.[23]

4.5.3 Indirect application of the PGC

[21] *Pretty v UK* (2002) 35 EHRR 1 para 72.
[22] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [342].
[23] For example, in the English medical setting the UK would be assisted by the current existence of relevant regulation/practice that would provide a safeguard; see especially 8.3-8.7.

The direct application of the PGC is not always possible in practice; as regards the generic right to enabled suicide there is scope for reasonable people to disagree as to when the right to enabled suicide has been secured in a safe way. The obligation on the UK courts and legislature to secure the right to enabled suicide in law is a requirement that there is an authorised, sincere, committed and rationally defensible *attempt* to protect the generic right (Beyleveld and Brownsword 1986, 183). The PGC therefore arguably recognises a form of 'margin of appreciation' applicable to English law (eg Beyleveld 2011, n 28). The 'margin of appreciation' justified by the PGC should be interpreted under the 'structural' conception as an approach to enforcement where a direct application of the generic right is not possible due to the complexities of the behaviour regulated (Letsas 2007, 90*ff.*). English law violates the hypothetical claimants' rights only when, once account is taken of various possible legal responses based on different risk-assessments, it is evident that the restrictive law fails to safeguard agency rationally or is disproportionate.

It is useful to expand briefly on the indirect requirements of the PGC. When the PGC cannot directly prescribe a course of conduct due to the capacity for reasonable disagreement, then the PGC still has a role in indirectly providing for the parameters by which the disagreement can be resolved. The PGC thus prescribes dispute resolution procedures, governed by principles of direct application of the PGC, in order to determine the legitimacy of the restrictive law. The principles governing such dispute resolution under the indirect application of the PGC are analogous to those governing decision-making with a 'weak discretion' to attempt to find the right answer (Beyleveld and Brownsword 1986, 178-9). The decision-making must be within the boundaries of an attempt, so the decision must be a 'good faith' attempt to create, interpret or disapply disputed law (Beyleveld and Brownsword 1986, 183). The content of a good faith attempt is as follows:

a) The positor is authorised as a rule-positor by the PGC;
b) The attempt is sincere: the authorised positor honestly believes he has done the best he can in the circumstances;
c) The attempt is a committed attempt: the authorised positor is guided by the ideal of trying to "get it right;" he is trying not to posit rules which require immoral behaviour…

e) The attempt must be rationally defensible (Beyleveld and Brownsword 1986, 183-84).

It is possible to support the ECtHR's evaluation of the rational consistency of the Suicide Act 1961 in *Pretty* under Article 8(2) in terms of the indirect PGC. The positor is the English courts, legislature or governmental body and may be taken to be authorised. It is necessary to determine whether such a body has made a good faith, sincere attempt to secure the generic rights by enacting the Suicide Act 1961. This determination requires evaluation of the attempt by the body to secure the generic right to suicide in the Suicide Act 1961 while seeking in a rationally necessary and proportionate way to minimise the risk of pressured and depressed suicide. The content of such a judgement is discussed in the subsequent chapter.

4.5.4 Failure to secure the generic right to enabled suicide by a legal rule

The failure to posit rules is a straightforward failure of the legislature and courts to secure the right to enabled suicide in law and the failure of government bodies to act according to such posited rules. The procedural failings identified by the House of Lords in *Purdy*,[24] referred to in the previous chapter, can therefore be understood as failures of the DPP to act pursuant to posited rules that took account of the claimant's generic right to enabled suicide (see 3.6.3; see also 6.5). The DPP did not, of course, act entirely arbitrarily or without basis in terms of posited rules as regards Purdy; as will be discussed in chapter 6, he acted pursuant to s2(4) of the Suicide Act 1961. However, the rules by which he restrained prosecution were found to be insufficiently articulated.[25] This finding is supported by the application of the PGC in this thesis, since the failure to posit rules effectively provides the foundation for the application of the PGC to such rules.

4.4.5 Conclusion

A violation of the hypothetical claimants' generic right to enabled suicide must be established by the direct/indirect applications of the PGC to English law. The judgements that inform

[24] *R (Purdy) v DPP* [2009] UKHL 45 (HL).
[25] *Ibid*.

these applications are complex and require an assessment of whether particular safeguards could be successfully enforced in practice. As will be argued in chapter 5, broad limitations are justifiable as necessary to sufficiently minimise the risk to the generic right to life of others. It is clear that it is not possible to justify any one set of safeguards under the direct application of the PGC alone, since any one formulation would be susceptible to reasonable objections. It is therefore necessary to accept that imperfect 'indirect' applications of the PGC might justifiably restrict certain exercises of the hypothetical rights (to "take my life" etc in 1.3.3). However, of course, this does not amount to a justification for arbitrary or clearly disproportionate restrictions on the generic right to enabled suicide under principles determined by the indirect application of the PGC.

4.6 Conclusion

The dialectically contingent method (DCM) establishes the PGC as a supreme principle of human rights which provides the justificatory criterion referred to in chapter 2 (see eg 2.2.3, 2.3). The PGC can therefore be used to defend the Gewirthian interpretation of the Convention right to enabled suicide in chapter 3, thus resolving the vagaries of subject, object, nature and resulting responsibility under such a right which were described in that chapter. The PGC therefore prescribes the basis upon which the right can be applied to English law and how it is to be weighed against the countervailing interest in life. However, this analysis has not so far considered the crucial question of what relevant *variables* must be taken into account by English laws if they are not to violate the generic rights of the hypothetical claimants (in 1.3.3). This question is considered in the next chapter.

Chapter 5: The PGC as a basis for proportionate legal restrictions on the generic right to enabled suicide

5.1 Introduction

The UK government's responsibility to secure the generic right to enabled suicide is justifiably limited by its responsibility to secure the generic right to life of other agents, but only in so far as necessary and without disproportionately restricting the former right. This chapter argues that the minimum content of such a judgement can be established in terms of the dialectically necessary implications of agency that also provide the foundation for human rights under the dialectically contingent method (see the previous chapter, 4.2), which goes further than the approach of the ECtHR in *Pretty v UK*.[1] In particular, the framework expands upon the justificatory basis of limitations on the generic right to enabled suicide in England and Wales based on the need for safeguards against depressed and pressured suicide. It is argued that the UK government is entitled to restrict the generic right to enabled suicide of claimants who cannot advert to a particular category of reasons for their suicide and whose behaviour is insufficiently indicative of their competence to commit suicide. In so far as the UK government can plausibly establish that it is unable to safely regulate such reasons and competence factors, without incurring a significant administrative burden, it may justifiably enact rules requiring English officials to interfere with enabled suicide.

This chapter will delineate a dialectically necessary framework for the assessment of the safety – in terms of the risk to the generic right to life of others – of legal procedures designed to enable officials to assess the competence of agents, such as the claimants, who seek enabled suicide. This framework will be used to establish justified criteria for a judgement by an official that a suicidal agent has sufficiently considered his reasons for committing suicide and has the dispositional and occurent competence to do so (5.2).[2] The criteria thus established are applied so as to outline fundamental principles underlying necessary safeguards (5.3), sub-divided as follows: safeguards to ensure that signalling of the

[1] *Pretty v UK* (2002) 35 EHRR 1 para 74.
[2] This is the definition of competent or 'rational' suicide adopted in this thesis (see 1.2.4).

suicidal purpose has occurred (5.4); safeguards against pressured suicide (5.5), safeguards against depressed suicide (5.6).

5.2 A dialectically necessary framework for official evaluations of competent suicide

5.2.1 Introduction

The constituent elements of the hypothetical claims refer to a situation in which an official (respondent) is in a position to act to interfere with the suicidal claimant (subject) as regards the enabled suicide (object) (see 1.3.3 and 2.2.3). Both the official and the suicidal claimant are necessarily agents in this scenario. This section will construct a dialectically necessary judgement in terms of an agent-official's dialectically necessarily understanding of an agent-claimant's suicidal purpose. To develop this scenario it is useful for the presentation of the argument to assign names and genders to the hypothetical agents. Thus Olivia is a hypothetical agent-official (O) who is empowered to interfere with the enabled suicide of suicidal agent-claimant Sam (S). Her judgement as to whether or not she should interfere is based on her assessment of S's ability to make a sufficiently informed and voluntary choice to commit suicide, which is a judgement about his competence to make that decision. It is argued that O dialectically necessarily must understand that the information relevant to S's decision covers his generic interests and that he must have the ability to make use of this information. However, before setting out the argument in full, it is useful to consider arguments critical of the premise that agents exist and act voluntarily, in order to provide context for the Gewirthian approach adopted.

5.2.2 Judgements about human capacity for voluntariness

The judgement that a 'person,' (without seeking to define this concept further in terms of agency – i.e. an 'ordinary person' as conventionally understood) is acting voluntarily is generally considered to be a judgement as to whether he is acting as he *desires*. However, it is clear that desire is only the *basis* for his voluntary choice; for a person to be acting voluntarily he must also be free to desire *as he chooses*, so that his choice to fulfil his desire is 'self-reflective,' unlike, for example, the desire associated with addiction (Christman 2012; Levy 1981; Frankfurt 1988). The concept of self-reflection is criticised as paradoxical on the

basis that it requires a division between 'first order' *desiring* and self-reflective 'second order' endorsement of these desires (Frankfurt 1988; Shroeter 2004; Ford 2005; Christman 2012). A person's 'self-reflective' desire is characterized by critics as an action based upon his desires and reasons that are *his* 'internal' desires and reasons, rather than another's 'external' reasons, but the possibility of a person possessing such independent reasoning and desires is attacked by critics as a radical claim given the social nature of personal reasoning (Friedman 1989; Benson 1991; Meyers 2000).

A prominent feminist criticism of the political and practical value of self-reflective reasoning has been advanced by certain feminist theorists, who argue that social conditions are necessary to achieve such a state and therefore it is the *social*, rather than individual, basis for action that has practical significance (Mackenzie and Stoljar 2000; Benson 2000). Feminist critics argue that a woman who has suffered historic disempowerment and who has come to accept her status, and submit to sexist norms, would be understood to have endorsed her submission on individualistic models of practical reason (eg Benson 1991), but this flaw is not evident on a social reasoning model. The argument that individual models of reasoning argument are compromised in this way has been termed 'false consciousness,' which conveys the idea that a woman has embraced a false value of herself which informs her self-reasoning (eg Meyers 2000).[3] The plausibility of false consciousness as undermining women's free choice, such critics argue, gains credence from the fact that there are women who endorse clearly disempowering identities and values, such as extreme sexist values (eg Cudd 2006, 160, 178-80; Oshana 2005, 53-7).

There are broadly two alternative models of non-individualistic self-reasoning that are advanced to address the problem of 'false consciousness': 'relational-reasoning' and 'social-reasoning'. The relational view of a person's self-reasoning finds that personal autonomy is plausible but it cannot be identified separately from the social and historical context within which a person is embedded (Christman 2004, 143). On this view only those persons within empowering social relationships have developed the capacities necessary for 'self-reflective'

[3] The theory of false consciousness has historically formed a decisive rejection of the value of the concept of autonomy as a concept of decisive importance to social science (eg Engels 1893 (Trans: Torr 1968): Engels to Franz Mehring) the broader contention of such theories that individual rights are nonsensical or pernicious is rejected by the confirmation of the value of 'human rights' interpreted as generic rights under the PGC (4.2).

reasoning, so that a person whose relationships are disempowering cannot necessarily develop the necessary capacities for self-reflection (eg Meyers 2004; Nedelsky 2012, 30-31, 51-53). The alternative social-reasoning thesis is that persons reason in social manner, not individually, which straightforwardly denies that anyone possesses 'self-reflection,' and thus the concept lacks practical value (eg Mackinnon 1987). On either view, the permission of enabled suicide for a competent 'person' is problematic since it potentially exposes her to self-destruction that is not her true desire despite it being her, individual, rationally considered purpose (eg Wolf 1996, 298-301; Donchin 2000).

As argued in the previous chapter (see 4.2), it is dialectically necessary for an *agent* to value his purposes and to consider himself to be a rational agent; therefore he contradicts his agency if he denies the existence of the capacity of other agents to freely purpose and reflect (see 4.3; Gewirth 1978, 31*ff*.). The conceptual approach to false consciousness under the relational and social theses of self-reflective reasoning is therefore ruled out by the PGC, because such approaches deny the practical value of individual selves (eg Gewirth 1978, 125, 156). Olivia (a hypothetical official), as an agent, cannot deny agency in *general* or she contradicts her own agency, even if she witnesses others embracing disempowering social trends; therefore the social-thesis is clearly incompatible with the dialectically necessary implications of her agency.

However, the idea of 'false consciousness' under the relational thesis raises a problem that is indirectly relevant to the PGC. If Olivia were able to accept her own agency and accept that others were equal in dignity and rights, but deny that any *other* 'persons' were agents, then the dialectically necessary implications of her agency would not require her to accept that such 'persons' possess generic interests or to grant them generic rights.[4] If this were possible then she could support the relational-thesis *indirectly* by finding that while *she* can act voluntarily, other 'persons' cannot, without contradicting the PGC or her contingent acceptance of human rights. However, it is argued below that this argument is not plausible because she is dialectically necessarily required to accept that all other 'persons' who display a sufficient level of self-reasoning behaviour are agents or risk harming such 'potential

[4] The possibility that an agent could deny the agency of others is raised by Beyleveld and Pattinson 2000.

agents' under the PGC; her dialectically necessary recognition of this fact also provides the basis for Olivia's acceptance that others act *voluntarily*.

5.2.3 The dialectically necessary and contingent basis for official evaluations of competent suicide

As Beyleveld and Pattinson have demonstrated, the PGC provides a framework for judgements about the existence of moral properties that are not empirically verifiable (2000, 43). This is termed the 'Precautionary Principle,' which Beyleveld and Pattinson have set out as follows:

> If there is no way of knowing whether or not X has property P, then, insofar as it is possible to do so, X must be assumed to have property P if the consequences (as measured by the [PGC]) of erring in presuming that X does not have P are worse than those of erring in presuming that X has P (and X must be assumed to not have P if the consequences of erring in presuming that X has P are worse than those of assuming that X does not have P). (Beyleveld and Pattinson 2000, 43)

On this basis, even though hypothetical official-agent Olivia (O) cannot strictly know that hypothetical suicidal-agent Sam (S) is an agent, she dialectically necessarily must judge that he does have that status on the basis that he *behaves likes an agent* (behaviour indicative of self-reflective reasoning and purposivity; see 1.4.4), and therefore that he possesses generic interests; otherwise she risks violating the PGC (Beyleveld and Pattinson 1998; 2000, 41*ff*.). If O is also committed to the premise that human beings are equal in dignity and rights, then she must (dialectically contingently) accept that S possesses generic *rights* (on the will conception) or risk violating the PGC. O must therefore judge that S is capable, as an agent, of exercising his generic right to enabled suicide (see 4.3) on the basis of his behaviour indicative of his self-reflecting reasoning and purposivity. Olivia's judgement is therefore that S has the dispositional competence to commit suicide, since dispositional competence is what S requires to exercise his generic right to enabled suicide (waive his generic right to life). The judgement by O that S is capable of giving valid reasons to commit suicide, and has the dispositional and occurent competence to weigh these reasons, is therefore dialectically

necessary. However, it is not the case that O is necessarily able to judge S's dispositional competence to commit suicide. Furthermore, S may not have occurent competence (eg Gewirth 1978, 38).

To illustrate the argument that there can be a dialectically necessarily judged 'valid reason' to commit suicide, it is useful to refer to a situation where Olivia would have dialectically necessary insight into Sam's suicide in order to preserve *another's* agency. An example would be where Sam desired to save his dying son by donating his vital organs. Olivia dialectically necessarily understands that Sam could grant equal weight to the continuation of his own agency as he could to his son's, since their agency is of equivalent value from O's perspective. The PGC cannot, of course, require an agent to sacrifice himself, but if Sam's *reason* for dying was to prevent the destruction of another's basic-generic interests or that other's life, then Olivia would have a dialectically necessary commitment to regard such reasons as a 'good reason' for his 'suicide'. On the same basis, where Sam's suicidal purpose is entirely based on his *own* condition Olivia has various dialectically necessary insights into that purpose.

Olivia must, dialectically necessarily, understand that, unlike other purposes, the *result* of suicide cannot be willed by Sam since death is not a generic condition of agency. Sam's purpose in saving his son was obviously based on his son's *agency*; similarly, where Sam's suicidal purpose is based on his condition, S's choice must be based on his *generic interests*, and not upon the result of his destruction, since if his apparent purpose is the latter then this must indicate that he has failed to bring his purpose to bear on *his agency*. Furthermore, O must judge that S has apparently taken into account the *entirety* of his generic interests rather than a partial assessment, since she must dialectically necessarily understand that his decision destroys the basis for his generic interests. Finally, O, as an official with the opportunity to interfere, must understand that if she fails to judge that S has not brought his will to bear on his agency when he commits suicide she will have exposed him to destruction of his agency. The unwanted destruction of S's agency is a basic harm (Gewirth 1978, 62-63). She must resolve her doubts as to her duty not to interfere with the enabler (E) in order to accept S's occurent competence as a dispositionally competent agent (in accordance with S's purpose). If the doubts cannot be resolved then O may interfere with E in order to prevent harm to S's

fundamental wellbeing, in accordance with the criterion of more probable harm (see as regards conflicts between agents eg Beyleveld and Pattinson 2000, 44).

In order for Olivia to judge that Sam's suicide is in accordance with his reasons in practice she must have knowledge of the basis for his reasoning, which she can necessarily establish if he can advert to a condition that undermines his experience of his generic interests (eg wellbeing, see as regards basic harms, Gewirth 1978, 212*ff.*), *and* if he can establish that his reasoning process is sufficiently self-oriented and free from interference (see as regards freedom, Gewirth 1978, 251*ff.*). It is submitted that Olivia's involvement in Sam's self-reflecting reasoning about his generic conditions for agency necessitates that she is 'close' or *proximate* to these conditions. Olivia's *proximity* to Sam's agency is established where she possesses reliable evidence of his generic conditions, which may be established simply by straightforward physical and temporal proximity, but only if his generic conditions can be straightforwardly evidenced to her senses – which would not normally be the case. Sam's condition might be of a nature that cannot be reliably evidenced to O in such a way (eg an internal medical condition that is internally evidenced only, or one that is predicted). The evidencing of generic conditions of wellbeing (eg life) is relatively straightforward compared to generic conditions of *freedom* which requires assessment of occurent freedom (eg restraint) and longer term self-control (Gewirth 1978, 253*ff.*). Olivia's judgement that Sam's self-control is sufficient to *commit suicide* necessitates a significant degree of oversight of his behaviour, given the complexity of his reasoning process and the basic harm to S if her assessment is deficient and she fails to interfere.

The operation of 'good reasons' to enable effective evaluation of considered, self-reflecting suicidal desires is illustrated by the example of Mary, referred to in the introduction (1.2.2). The reason for Mary's suicide, which her family ultimately assisted in, was second-stage terminal breast cancer (Shavelson 1995, 159).[5] Her stepdaughter, Anne, with whom Mary was most intimate, records the first time that she became aware of her step-mother's condition and suicidal desire, which was many months before the final stage of the disease and her step-mother's assisted suicide. The conversation was recorded as follows:

[5] Mary's assisted suicide was not prosecuted, but was recorded for posterity by the family as recorded by Shavelson 1995, 158.

> [Mary] "The last thing I learned from my mother… was how to die. It was an important lesson. Now I can pass it on to you… As I continue to deteriorate… it will be obscene to prop up what's left of me and have the family come take a look at it. So I've arranged to die before that." (Shavelson 1995, 159)

Anne's immediate response was to encourage her mother to reconsider and to engage the wider family; she did not accept her mother's wish at that point. Her reason for doubting her mother's purpose was her mother's wavering desire to commit suicide on her own terms post-diagnosis (Shavelson 1995, 160). However, as her mother deteriorated, Anne recorded that her step-mother's desire become more 'real' to her (Shavelson 1995, 160). Much later, when Mary was admitted to the cancer ward, the idea of suicide, which till then had been vague and transitive, is recorded as having become definite (Shavelson 1995, 183). Anne describes an implicit understanding that had arisen between them at this point, in favour of suicide (Shavelson 1995, 183).

Mary's mental state, as evidenced by Anne, is portrayed as engaged and sensitive to the judgement; the conversations recorded between them demonstrate a closeness of personality in which both parties engage with each other's self-reasoning. Anne sympathised with her step-mother's prevarications, and argued against the defects in Mary's reasoning when it was still un-thought out. Mary was familiar with her step-mother's self-reasoning, since their close relationship was such that they were *close* as self-reasoners; this is the sense in which closeness or proximity of *agency* is understood in this thesis. However, for the members of Mary's family who were less close than Anne, it is recorded that it was the fact of Mary's terminal cancer that most convinced them (Shavelson 1995, 188). It is argued that the position of an official judging the purpose of a suicidal potentially incompetent agent (PIA) can be analogised to an extent with the position of Anne's relatives who were not close to Mary's self-reasoning process; an official's lack of intimacy means that they would have incomplete information on which to judge Mary's process of self-reasoning. In the case of an official (Olivia), who is not in a close relationship with a suicidal agent (Sam), she must approach his self-regarding decision in the neutral/formal terms of S's *condition* as is recorded as being the case in respect of Mary's wider family.

The primary difficulty in framing effective *law* to achieve sufficient proximity between officials and suicidal agents, enabling the former to achieve the necessary oversight, consists of the significant administrative burden that the practical enforcement of such law would entail (discussed further in subsequent sections, see 5.4-5.6). Furthermore, direct oversight by an official is burdensome to suicidal agents *in itself* and is therefore counterproductive to an extent. The necessity of official proximity with the purposes of suicidal agents forms the basis of libertarian humanist arguments *against* legalisation of assisted suicide on the basis that it would require legal intrusion into a situation in which such an 'alienating' presence has no place (eg Yuill 2013, 146-47). The following discussion will therefore seek to establish a basis upon which Olivia can demonstrate that Sam has weighed his decision to commit suicide with the minimum proximity that can reasonably be judged to be 'safe' in order to minimise both burdens. However, it is the administrative burden that is decisive at this emergent stage in English law, and therefore this chapter will focus upon that burden. It is submitted in the next section that proximity can be reduced within 'safe' limits where Olivia's evaluation has a dialectically necessary basis so that she understands Sam's 'good reason' to commit suicide, limiting the scope of her assessment (5.2.4), but that she must still evaluate S's *competence* to advance such a reason (see below 5.2.5).

5.2.4 A dialectically necessary basis for accepting reasons to commit suicide

The dialectically necessary basis of Olivia's evaluation of Sam's suicidal decision, as set out in the previous section, is her self-oriented assessment of his generic interests (eg Gewirth 1998, 114). An alternative characterisation of Sam's decision is that it is 'on his terms' in a way that is based on his current experiences, values and identity.[6] The title of Debbie Purdy's memoir *It's not because I want to die* (2010) captures the essence of this idea, which is that her suicidal desire stems from dying in accordance with her values rather than because she does not value her life (see eg Purdy 2010, 231). Olivia can only accept that Sam has conducted such an assessment of his generic interests on the basis that he has the dispositional competence to conduct it, which requires her to establish that he has the necessary self-control and understanding to make such a decision. However, S's assessment

[6] *Pretty v UK* (2002) 35 EHRR 1, para 58.

of conditions affecting his generic interests can be extremely complex and involve a range of variables whose import he might find difficult to communicate to O.

The more complex is Sam's assessment of his generic interests, the greater the requisite degree of proximity O must achieve if she is to ensure that he is in a condition to make such an assessment. If Sam commits suicide for no obvious condition at all, for example because S is merely 'tired of life,' then his purpose is not capable of being a reason for suicide as a rule, but is, rather, S's unique assessment of his generic interests; such an assessment necessitates the degree of intimacy between Mary and Anne, considered above, if O is to understand S's purpose (eg SOARS 2014). If Sam's condition affects his non-basic generic interests then his purpose can be generalised to an extent, but the information required necessitates a high degree of proximity between O and S. It is submitted that there are conditions that so undermine S's basic generic interests (i.e. his fundamental wellbeing) that O must dialectically necessarily accept them as being *capable* of being weighed by S against the continuation of his agency (see 5.2.3). Where Sam advances such a basic condition as a reason, Olivia's assessment requires a qualitatively lesser degree of oversight than when he advances a non-basic condition or a non-condition as a reason for his suicide.

A condition that fundamentally undermines Sam's basic generic interests could be described as a condition of 'extreme suffering', as is explained below; this condition is used as a limitation on forms of enabled suicide in certain regimes that permit official involvement in enabled suicide (eg 'unbearable suffering' in the Netherlands, see further 9.4.3). The use of 'extreme suffering' as the basis for official regulation of assisted suicide and voluntary euthanasia is controversial since it is viewed as imposing an artificial quantification of another's suffering (eg Commission on Assisted Dying 2011, 305; Sumner 2011, 171; Hartogh 2013, 124*ff*.). However, the concept of extreme suffering is understood by O in terms of Sam's *agency*, so she has a dialectically necessary reason for regarding Sam as having a good reason to die if he is suffering from a condition that degrades his *basic* generic interests, thus fundamentally undermining his capacity to act. The definition of 'extreme suffering' is therefore not limited to pain, but to conditions that radically diminish capacity (i.e. fundamentally undermine a suicidal agent's basic generic interests). It is also not limited to *current experience* of the condition or physiological phenomena, such as pain; Pretty's

prediction that she *would* die by suffocation[7] is as much 'suffering' as Nicklinson's experience of paralysis[8] on this framework.

Sam must, of course, evidence his extreme suffering to Olivia if it is to be advanced as a good reason for his suicide. Olivia's understanding of his suffering is in terms of agency, as stated above, and it is unnecessary to develop a detailed account of specific conditions that undermine S's basic interests to the requisite extent to amount to 'extreme' suffering. It is, however, important to emphasise that the condition of extreme suffering takes account of the availability of alternatives. It is commonly objected to an 'extreme suffering' criterion that rather than legalise assisted suicide a state should provide what is needed to support people who are suffering so that they can learn to accept their disability (eg Kaufert 1994, 58). However, it is argued that the proposed framework necessarily accounts for such alternatives. Olivia's dialectically necessary understanding of the severity of Sam's condition is based on an account of his condition as undermining his basic generic interests, so the availability of measures that enable S to *develop* his basic generic interests to compensate negates her judgement that his condition is severe.

Olivia's judgement about alternatives is founded upon S's basic generic interests and also upon the *time* and *opportunity* S has to compensate for the complained of condition (eg Gewirth 1998, chapter 4). A common example of limited time and opportunity arises where S is in the late stage of secondary cancer. The converse arises in a case of paralysis, as in the case of Tony Nicklinson,[9] where S has many years to live and various possible opportunities of developing alternative capacities. An extreme example of time and opportunity is provided by the assisted suicide of Daniel James, whose family ultimately facilitated his request for assisted suicide two years after he became paralysed as a young man of 18 (it was, furthermore, accepted that his case did not necessitate prosecution, see DPP 2008). His capacity to have *changed* his self-regarding reasoning process, and to have developed his generic interests to compensate for his paralysed state, was still relatively untested when he ended his life.

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[7] *Pretty v UK* (2002) 35 EHRR 1, para 7.
[8] *R (Nicklinson) v Ministry of Justice* [2012] EWHC 2381.
[9] *R (Nicklinson) v Ministry of Justice* [2012] EWHC 2381.

5.2.5 Competence to commit suicide on the basis of a condition of extreme suffering

Olivia's judgement as to Sam's reason for suicide on the basis of his condition of extreme suffering encompasses a judgement about whether he is free to arrive at such an assessment. As discussed above, S's freedom consists of his dispositional/occurent competence to arrive at his decision and is based on her understanding of his behaviour (see 5.2.3). Until O has resolved the question of S's competence he is, from her perspective, potentially incompetent to commit suicide at this point in time; therefore, S may be described as a *suicidal potentially incompetent agent* (a suicidal PIA for short) until she has resolved the question of his competence to commit suicide. If she interferes with S's enabler and S has competence, then she harms S by interfering with his purpose since his freedom to act upon his purposes is a generic good (Gewirth 1978, 52; see also 2.6 and 4.3). However, S must dialectically necessarily understand that O's judgement about S's competence to commit suicide is to be distinguished from any other judgement about S's competence to exercise his generic rights, since suicide is both a uniquely harmful purpose and requires a uniquely difficult self-regarding judgement (see 5.2.3).

It is dialectically necessary for Olivia to set a threshold for judging Sam's occurent competence that is higher than for his other decisions, and she must not make a precipitate judgement that S has competence. Therefore it is argued that the judgement that S has competence is not one that should be made solely on the basis that S is an ostensible agent, has the time to consider his decision, and is (directly) informed, and in control of his actions (eg Gewirth 1978, 31*ff*.). However, the threshold must be achievable by S since she must (dialectically contingently) judge him to be capable of making decisions about his generic interests (see as regards variable thresholds for competence: Beyleveld and Brownsword 2007, 110). It is therefore argued that O can justifiably set a general threshold for competence that encompasses a broad conception of voluntariness and self-regard which encompasses his *self-esteem*.

Sam's dispositional competence is assumed to be that of an ostensible agent, and therefore undiminished by severe depression or serious mental health problems. Olivia must understand 'severe depression',[10] and other problems with S's mental health, in terms of agency to mean that S is in a state in which he would evidently be disinterested in, or oblivious to, his generic interests. Olivia dialectically necessarily must judge Sam on the basis of evidence that he primarily reasons and acts without regard to his generic interests (eg Gewirth 1998, 79-80; see below 5.4.4 and 5.5). The conception of depression is therefore not 'unhappiness' so much as *self-obliviousness* (or 'self-alienation' i.e. remoteness from one's desires; Gewirth 1998 119-120). The state of severe depression may be contrasted with mild depression, which is a disposition that does not contradict general task-competence. But both states would mean that S lacks self-esteem to arrive at a fair assessment of his generic interests sufficient to bring his agency to an end. As discussed below, in practice, the need to implement effective safeguards against depression creates an acute problem for the regulation of enabled suicide in relation to categories of suicidal potentially incompetent agents who are suffering.

Olivia's judgement that Sam is free from mild depression is necessarily flexible, being particular to Sam, but is demonstrated by certain forms of predominantly *positive* self-regarding behaviours. Olivia's judgement should be guided by evidence that S possesses an 'abiding self-esteem in that [he] views the worth of his goals as reflecting his own worth as a rational person' (Gewirth 1998, 126). Self-esteem encompasses behaviour that is 'self-reliant' or 'courageous' since these are prudential virtues of character related to personal responsibility (Gewirth 1998, 126). These factors weigh in favour of a disposition to value the generic interests; conversely, if Olivia found Sam to be dependent or timid then this would detract from such an assessment. Also indicative is a disposition towards temperance and prudence, in terms of judging one's desires judiciously, as opposed to impulsivity (Gewirth 1998, 126). An example of behaviour indicative of a disposition towards such prudential virtues is provided by the examples of Pretty and Purdy. In the *Pretty*[11] case and in

[10] The definition of depression used in this thesis is not one that is reliant, in principle, upon the endorsement of medical institutions, but on necessary judgement about self-valuing of agents under the PGC, although, of course, clinical and psychological assessment, if reliable, could contribute to the reliability of official assessment of self-esteem.

[11] *R (Purdy) v DPP* [2009] UKHL 45 (HL).

Purdy's memoir the general disposition of both individuals to face adversity with courage is evident (Purdy 2010, 223*ff*.).[12]

The necessary justifiability of exclusion of mild depression by Olivia creates a crucial paradox whereby those who have the most generically understandable reasons to commit suicide, those who are suffering, are also likely to experience diminished competence. This paradox lies behind a common objection to reliance on an 'extreme suffering' criterion on the basis that people who experience extreme suffering (and incapacity) fall into depression and are more given to suicidal behaviour which is incompetent (eg Keown 2012, 97-98). There are prominent examples of individuals with such conditions, such as Stephen Hawking, who seriously considered suicide due to their condition, but ultimately overcame their spells of depression and chose to live long and fulfilling lives (eg Hawking 2013a).[13]

In addition to Sam's dispositional competence, Olivia must judge him to possess the necessary occurent competence if her dialectically necessary assessment of his competence is to be complete. The most basic conditions for occurent competence are freedom from physical restraint and basic self-control. Where Sam is subject to interference or coercion by the enabler or another he is clearly incompetent to make his suicidal decisions, as he would be for most decisions regarding his generic interests (eg Gewirth 1998, 113).[14] Similarly, if S's suicidal action is automatic then he is incompetent (Gewirth 1978, 31); an example would be a suicidal action taken as a result of somnambulism (i.e. sleepwalking). These basic criteria represent the fundamental basis of Olivia's judgement that Sam is occurently incompetent. In both cases S fails to manifest self-control since he is subject to evident interference from external forces at the point of his 'suicidal decision'. The basis of Olivia's judgement is that S's behaviour indicates that he is not choosing for *himself* but primarily for

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[12] *Pretty v UK* (2002) 35 EHRR 1, para 72.

[13] It should be noted that Stephen Hawking is in favour of the right to assisted suicide despite his experiences Saunders 2012 *cf* BBC 2013a.

[14] Borrowing Gewirth's readily accessible terminology the basic nature of voluntary action as follows (Gewirth 1978, 31):

> Negatively, the behaviours must not occur from one or more of the following kind of cause: (a) external causes such as direct compulsion, physical or psychological, by someone or something; (b) internal causes… that decisively contribute, in ways beyond his control, to the occurrence of the behaviour...

an external agency or a factor external to himself, or, as in the case of automatism, Sam's self-purpose is entirely displaced. Obviously Olivia is justified in setting a much higher threshold in relation to Sam's behaviour than merely establishing that he is being exclusively directed by another or that his will has been entirely displaced. However, the threshold she sets cannot contradict her dialectically necessary judgement, under precaution, that Sam, as an agent, acts self-reflectingly when his behaviour evidences that he has brought his will to bear on the condition of 'extreme suffering' that forms the basis of his suicidal decision.

Olivia's assessment of Sam's self-control, beyond mere physical restraint, must begin with her understanding of Sam's reason for acting. Olivia must understand that Sam's behaviour is primarily self-directed when there is evidence that he is acting for his own ends based on *his* assessment of his fundamental generic interests. Olivia must therefore judge that Sam lacks occurent competence where his suicide is 'pressured' (see in general eg Battin 1996, 145–157). The concept of 'pressure', understood in terms of Olivia's necessary assessment of Sam's occurent competence, arises where an influencing agent (Z) has capacity to control Sam's basic generic interests and Z exercises this capacity. This conception of 'pressure' is distinguished from *encouragement* of Sam to commit suicide on *his own terms* since encouragement implies support of Sam's purpose. English law encompasses both pressuring actions and encouraging actions (see 6.4); while the proscription of encouragement departs from the principled framework advanced in this section, encouraging or pressuring actions may justifiably give Olivia (as an official who is empowered to interfere with the suicidal purposes of PIAs) cause to doubt as to whether Z's apparent encouragement is in fact a pressuring action (see below 5.6).

Olivia must also judge Sam to lack occurent competence where his suicidal action is primarily driven by self-disregard due to emotion, such as pain or despair. As was discussed above as regards dispositional incompetence, where Sam's actions are characterised by disregard for his generic interests, Sam's action is characterised as 'depressed' (Gewirth 1978, 32*ff*.). Olivia's judgement of Sam's lack of occurent competence on this basis is therefore termed 'occurent depression'. The phenomenon of occurent depression is captured in the familiar portrayal of a suicidal action as an 'act of despair'. The phenomenon of 'safe' regulated assisted suicide, which is considered in this thesis is, however, far removed from such actions. As is discussed below, the fundamental necessity of engaging with official

procedures to establish that the suicidal PIA has signalled his suicidal purpose necessarily requires greater consideration than is compatible with an act of despair (see 5.4).

5.2.6 Conclusion

To summarise the steps in the above argument: an agent-official's (Olivia's) judgement necessarily begins with a suicidal potentially incompetent agent's (Sam's) *behaviour*; she cannot *know* that Sam is an agent, but she discerns his status as an agent from his (dispositionally/occurently) purposive actions and, similarly, she is required to accept that Sam's choice, as the choice of an ostensible agent, is one that he is entitled to make, even though his action is self-destructive. However, Sam's status as an ostensible agent does not mean that Olivia must dialectically necessarily accept that he has brought his will to bear on his *suicidal* choice. If she is to judge that Sam is competent she must make herself aware that his decision was not a self-destructive one, but rather a considered weighing of his generic interests and continued agency. Where Sam's decision is based on a condition of 'extreme suffering' affecting his basic generic interests then the rational basis of S's decision can be evidenced to O, who must necessarily accept that such a condition is capable of being weighed against the continuation of S's agency.

The complexity of O's assessment of S's reasoning behaviour is qualitatively reduced where S advances a condition of extreme suffering. Finally, Olivia must consider Sam's competence to commit suicide on the basis of his evidenced condition. Olivia dialectically necessarily understands that the threshold for Sam's dispositional and occurent competence to commit suicide is higher than for other self-regarding decisions; on this basis she adopts an expansive and individually-oriented judgement as to Sam's behaviour indicative of lack of competence. Specifically, she regards S's behaviour to be incompetent where it indicates that his suicide is non-self-esteeming (mild depression), or indirectly influenced by those close to him (pressure). The next section will apply this framework to the justifiability of laws restricting the generic right to enabled suicide of the hypothetical claimants on the basis of the administrative burden of creating 'safe' procedures to oversee such claims.

5.3 Necessary and proportionate safeguards: signalling procedure and minimising the risk of pressured and depressed suicide

The ECtHR's finding that the near-absolute prohibition on assisted suicide in English law was necessary to safeguard the 'weak and vulnerable' in *Pretty*[15] is possibly compatible with the above framework. A proportionate restriction upon the right to enabled suicide is one that is necessary to minimise the risk that officials would fail to prevent suicidal agents who are incompetent from being enabled to carry out their (compromised) purposes. The dialectically necessary implications of agency discussed in the previous section provide the basis for a PGC-compatible justification for safeguards limiting claims to those based upon 'extreme suffering'. It also justifies an expansive competence test providing the basis for official judgements. The UK government cannot therefore defend an absolute discretion to restrict assisted suicide. Furthermore, the government cannot successfully argue, as it did in the *Pretty v UK*[16] case, that court proceedings that had established the competence of one individual (i.e. Diane Pretty) could not establish the competence of others. However, beyond these points, there is a broad discretion to justify restrictions upon a minimal generic right to enabled suicide on the basis of a maximal protection of the generic right to life.

There are obviously a broad range of plausible forms of regulation that could justifiably restrict claims to enabled suicide in order to minimise the risk of pressured or depressed suicide. The justifiability of such plausible alternative forms of legal regulation must be determined on the basis of their capacity to protect the generic right to life of suicidal potentially incompetent agents (PIAs) while nevertheless protecting the right to enabled suicide of potentially competent claimants. Thus, the near-absolute prohibition on assisted suicide in English law is justifiable only if there is a defensible basis for finding that there is no procedural safeguard that could sufficiently minimise the risk that incompetent agents would be enabled to commit suicide (who might come within almost all the categories of claimant seeking enabled suicide).

The near-absolute prohibition on enabled suicide in English law is clearly disproportionate under a direct application of the PGC (see previous chapter, 4.4.2). However, as discussed in

[15] In the ECtHR's terminology the UK government was 'entitled to regulate' assisted suicide under the criminal law in this way, *Pretty v UK* (2002) 35 EHRR 1 para 74.
[16] *Ibid.*

the previous chapter, the application of the PGC to the practical realities of law-making can justify laws that depart from formal adherence to the PGC (see 4.4.3). Such an indirect justification can be defended where the complexity of the behaviour regulated means that reasonable agents could disagree as to what a good faith, sincere and committed attempt to apply the PGC in practice would involve (see 4.4.3). Furthermore, the UK government's responsibility to secure the generic right to enabled suicide in law in order to avoid a *violation* of the rights of the hypothetical claimants is a *minimal* responsibility, and therefore an extensive commitment of administrative resources, such as the creation and enforcement of *certain* regulatory safeguards, would exceed the government's duty (see previous chapter 4.2). Consideration of the safeguards below will demonstrate that the arguments the government would wish to advance as to the burdensome nature of certain safeguards are valid, whereas that will not be found to be the case in respect of others.

The most fundamental feature of necessary safeguards is that a suicidal decision is *signalled* to officials (see in the context of consent in the law generally, Beyleveld and Brownsword 2007, chapter 7). By 'signalling' is meant the means by which the suicidal PIA expresses their choice to commit suicide to officials. If English law is to provide any safeguard whatsoever it must, most fundamentally, treat the signalling of the suicidal choice as crucial, and seek to empower officials to interfere with enabling actions where it is not clear that such signalling has occurred. The above framework provides the basis for justifying a condition of extreme suffering as a category of 'good reason' for suicide, so that where such a condition is not evidenced then it would be justifiable to exclude such claims from the signalling procedure and empower officials to interfere with a person enabling such suicidal conduct.

The justifiability of restrictions upon the hypothetical claims in order to minimise the risk of defective signalling by suicidal PIAs is not evenly applicable between the different claims considered in this thesis ("take my life," "help me die," "end my suffering" "let me die", see 1.3.3). In particular, safeguards concerning signalled acceptance of forms of assistance *not* amounting to killing the suicidal PIA, do not clearly violate the UK government's minimal responsibility under the generic right to life, since the suicidal action itself remains under the control of the claimant (see 5.4.2). There is also variation in the way in which different *forms* of exercise of the right affect signalling; where the right is exercised by advance decision then, of course, it is necessary to establish that withdrawal of such a decision has not

occurred, which is particularly the case where a signalled future decision cannot be withdrawn at the point of the suicidal 'action' (see 5.4.8). It is argued that the near-absolute prohibition on all forms of enabled suicide is not defensible solely on the basis of the administrative burden of framing law to safeguard signalling, since a prohibition clearly goes beyond what is necessary to meet such a burden as regards certain claimants. Furthermore, as discussed below, justifying English law in such terms is undermined by inconsistencies whereby enabled suicide is permitted in narrow circumstances which would justify the *greatest* degree of procedural oversight (eg advanced decisions) and restricted in circumstances that justify minimal or no oversight of signalling (eg assistance in travelling abroad to receive an enabled suicide).

The above framework establishes the justifiability of safeguards that go beyond procedural signalling to encompass the substantive evaluation of the reasoning process of the suicidal PIA in terms of his competence. It is argued below that such an evaluation provides a defensible basis upon which all the rights claims ("take my life" etc, see 1.3.3) may generally be restricted in law, which is due to the administrative burden created by the necessity of official assessment of dispositional and occurent 'self-esteeming' suicidal decisions. It is argued that the ability to create generic rules to police self-control is undermined by the need for flexibility in such procedures, which is a familiar objection to legal reform of assisted suicide in general on the basis that it creates a 'slippery slope' to unsafe or even involuntary enabled 'suicide'. Against these objections to reform it will be argued that the failure to provide even an *exceptional procedure* for official evaluation of the 'self-control' of suicidal decisions is a violation of the generic right to enabled suicide.

5.4 Signalling procedure and the potential for abuse

5.4.1 Introduction

In *Pretty v UK* the government argued successfully that officially sanctioning the applicant's assisted suicide would create a dangerous precedent, despite accepting that officials had

established that *her* reasons for suicide were rational and that she was competent.[17] This was because creation of such a precedent risked the incompetent suicide of *others* who would seek to advance similar reasons, but whose competence had not, obviously, been assured by the judgement.[18] The above framework has established that the judgement that English officials are unable to minimise the risk of incompetent suicide sufficiently can be conceived of as necessarily including an assessment of the administrative burden of creating sufficient *proximity* between officials and the suicidal agents that they judge (see 5.2.3). The relevant conception of proximity is the proximity of agency, such that officials can judge a suicidal PIA's reasoning about his generic interests. If sufficient proximity is established then the suicidal PIA's reasoning must, dialectically necessarily, be capable of meeting the requirement of protecting his generic right to life without exercising a power to interfere with his suicidal purpose (it can be assumed that attempts at judging would be sincere, in good faith etc – see 4.3).

This section examines the safety of procedures designed to secure official capacity to engage with the reasoning process of the hypothetical claimants and other suicidal PIAs. It may be assumed that English law may justifiably impose a requirement that if the suicidal PIA fails to signal directly to an official then – assuming of course that the official becomes aware of the enabling process – she has a basis for exercising her power to interfere (by interfering with the person enabling the suicide of the PIA). The section will firstly address the preliminary issue of the enabling action sought by the PIA. The section will secondly turn to the fundamental nature of procedures governing the official evaluation of the signalling of the decision and the reason for it by suicidal PIAs. A justifiable burden of proof standard is set out in outline and applied to official evaluations of reasons given by the suicidal PIA, the factual basis for his given reasons and his reasoning behaviour that confirms or denies that the given reasons are the basis of his decision.

5.4.2 Signalling and the enabling action

[17] *Pretty v UK* (2002) 35 EHRR 1 para 73.
[18] *Ibid*, para 76.

The justification for safeguards for signalling and withdrawal differs between the "take my life" and "help me die" claims, since a *suicidal action* is itself 'signalling' a personal choice to die and this does not occur where the enabler performs the final act. A dramatic example of the evident danger posed by an apparent enabler who represents wrongful killings as permissible ones is provided by the doctor Harold Shipman, ultimately convicted of murder, who was found to have disguised the deaths of certain of his victims by lethal injections as permissible treatments (eg Shipman Inquiry 2003, 11.70; see further chapter 7). It is useful to expand briefly upon the forms of conduct that this thesis is concerned with (referred to briefly in 1.2.4). This thesis is directed towards the following types of enabling action:

1) Enabling by:
    a. providing material assistance in acquiring a suicidal 'device'[19] from another assister;
    b. providing a suicidal 'device;'
    c. abstaining from providing a life-preserving 'device' (this conduct is only 'enabling a suicidal purpose' if the suicidal signalling is the decisive basis for the 'enabler's' conduct);
2) Which is:
    a. entirely controlled by the suicidal PIA; or
    b. controlled by the suicidal PIA but requires the enabler's presence in relation ot the final act (eg to 'set up' the device); or
    c. cannot be controlled by the suicidal PIA.

English law currently proscribes all instances of such (intentional) assistance except that of abstaining from vital treatment (1c), although there are narrow circumstances in which other forms are possible (discussed in chapters 6-8).

Official interference with the enabler's act is potentially justifiable, regardless of the enabler's action and also of the suicidal PIA's control over the killing act, with the purpose of evaluating the suicidal PIA's competence to authorise enabling actions taken on his behalf.

[19] I.e an object designed for that purpose.

However, there are crucial distinctions between official assessments of signalled decisions by suicidal PIAs in each case. In cases in which the suicidal PIA retains control of the killing act (within (2a) and (2b)) officials would have no reason to doubt that the final action was under the control of the suicidal PIA, as opposed to cases where he does not retain such control (2c); on this basis, official proximity at the point of the killing in the latter case is required/justifiable in order to establish that the 'suicide' is indeed a self-regarding action.

In order to illustrate the different forms of enabling action, and their implications in terms of signalling procedure it is useful to relate the above criteria to the various suicidal claimants who sought to claim a Convention right to enabled suicide, which were considered in chapter 3. Assistance amounting to provision of a 'device' entirely controlled by the PIA occurred in *Haas*[20] and *Gross*;[21] in both instances the enabling action, the provision of pentobarbital, was discrete from the suicidal action (1b and 2a). In *Purdy*[22] the actions of Purdy's husband can be characterised in terms of (1a and 2b). Her husband agreed to assist her in acquiring a suicidal device in Switzerland although he would not provide it himself (1a); she would have been able to control the device although he would have been present at the final stage (2b) (Purdy 2010, 232). Interference with such indirect assistance is justified on the same basis as interference with the assister who provides the suicidal device. Similarly, the claimant in *Pretty* can be characterised in terms of (1b) and (2b) since she sought an assurance that her husband would not be prosecuted for providing her with a suicidal 'device' (1b) which she could control in terms of the killing act (2b). The fact that the assistance required would not have amounted to performing the killing action, because she could swallow etc, would have meant that, as long as this fact was apparent, her husband's action would remain *assistance* in a lethal purpose. Only in the case of *Nicklinson* was the (original) paralysed claimant so incapacitated as to raise a claim to voluntary euthanasia in which the final act was not controlled by him (2c).[23]

5.4.3 Advanced suicidal signalling

[20] *Haas v Switzerland* (2011) 53 EHRR 33.
[21] *Gross v Switzerland* (App no 67810/10) judgment of 14th May 2013.
[22] *R (Purdy) v DPP* [2009] UKHL 45.
[23] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200.

The signalling model above anticipates that there is a division between the signalled authorisation of assistance in suicide and the final lethal act in which officials can assess the signalled suicidal purpose. As will be discussed in chapters 7 and 8, English law, anomalously, recognises certain cases of enabled suicide by refusal of vital treatment in which the suicide occurs contemporaneously with signalling; this is, rightly, condemned as unsafe on the basis that most safeguards cannot operate (see below, and see 8.3*ff*.). It is clearly justifiable, in general, to require signalling by suicidal PIAs of their suicidal intention to officials in advance, which means that officials have the opportunity (i.e. time and resources) to achieve sufficient proximity with the suicidal PIA's purpose in order to consider it. If he was to withdraw his request during the time in which officials were to consider the suicidal PIA's reasoning, then, of course, he has not signalled a suicidal purpose; the basis of a judgement that such a withdrawal has occurred is considered below (see 5.4.8).

A common form of suicidal signalling, considered in this thesis in full in chapter 8, is to stipulate a situation in which a suicidal potentially incompetent ostensible agent (who is an ostensible agent, see the above framework) *will be* an occurent or dispositional non-ostensible agent when the final act is performed (e.g. temporarily or permanently unconscious); thus he is entirely lacking in control of the final, killing, act. The lack of control over the final act justifies a significant degree of official proximity (see 5.4.2). English law actually *permits* such advanced suicidal decisions for a narrow form of enabling conduct by the omission to provide a life-preserving 'device'. The implications for *withdrawal* are considered further below; it is necessary to consider briefly a novel objection to the *conception* of such conduct as suicidal signalling when the PIA specifies a future time when he lacks the *dispositional competence* to understand his decision but retains ostensible agency to an extent. This occurs in relation to a prevalent form of suicidal signalling where a person has dementia, which has received a degree of legal acceptance.

In the case of progressive dementia it is not uncommon for a suicidal PIA to sign a 'living will' in which his decision to commit suicide is signalled to doctors who might provide life-preserving treatment to him, requesting that they evaluate the state of his dementia before they do so, and if he has reached a specified state of dementia to abstain from providing him with such treatment. Suicidal PIAs typically issue such 'living wills' because they anticipate the destruction of their competence and *alteration* of their personality (Hertogh 2009, 100;

Buchanan 1998, 280; Ott 2009). The intuitively unappealing prospect that a prior personality could 'direct' the destruction of a subsequent personality has been theorised as a 'personal identity' objection to such decisions (eg Dresser 1986; 1995). This objection can, it is argued, be interpreted in a manner that engages the above framework in so far as 'personal identity' can be defined as behaviour manifesting self-reflecting purposivity. It is submitted that it is, of course, possible to justifiably determine that a human body contains multiple agencies, and therefore it is also possibly justifiable that multiple agencies could exist subsequently in the same body (see 5.2.3). It is therefore necessary to elaborate briefly upon this objection to advanced decisions based on future incompetence.

The 'personal identity' objection is, in general terms, based on the notion that the personality of the agent who made the original suicidal decision is no longer in existence (Buchanan and Brock 1986; Buchanan 1998, 280; Lewis 2002, 581-83). In terms of agency, a discrete human 'body' could manifest behaviour indicative of multiple discrete agents in the case of conjoined twins or, arguably, developed cases of multiple personality disorder. Logically, if agent A were sharing a body with agent B then both possess generic interests and both possess generic rights against interference, including by the other. However, in practice, an agent's body manifests his rational purposivity through his self-reflecting reasoning behaviour and, beyond exceptional circumstances, there is limited scope to argue that an official should judge a suicidal PIA to have ceased to exist and been 'replaced'. It is contrary to the PGC for an official to reasonably doubt that a suicidal PIA (S) has been destroyed and replaced by a new agent (Z) without first establishing that S's experiences of his generic interests has been entirely destroyed (and replaced). The judgement that destruction of agency has occurred without the destruction of an agent's body or even the absence of outward manifestation of self-reflecting behaviour (since Z apparently immediately replaced S) is a necessarily doubtful judgement under the PGC (see as regards the precautionary basis for according duties of protection to marginal agents Beyleveld and Pattinson 2000, 44*ff*.). A far more readily justifiable basis for officials to reject such advanced decisions is a reasonable doubt that the signalled decision has been withdrawn, which is a judgement that is common to all forms of advanced suicidal signalling and is considered below (5.4.8).

5.4.4 'Proximity' and reasonable doubt

On the framework above, it was found that 'sufficient proximity' between an official (O) and a suicidal potentially incompetent agent (S) was necessary before O was capable of judging S to be competent. The relevant conception of proximity is that of agents in a close relationship, as defined above (see 5.2.3); it was conceded in the above framework that, in practice, the administrative burden of enabling officials to judge suicidal PIAs to be competent in general would far exceed the minimal requirements of the generic right to enabled suicide. The framework established a PGC-compatible basis for justifying a limited engagement by an official (O) with a suicidal PIA's (S's) reasoning due to S's condition of extreme suffering, thus limiting O's engagement with S's self-reflecting purposivity in relation to S's competence to advance that particular reason. Therefore, where S is judged to have advanced this reason *and* is judged to possess dispositional and occurent competence to understand it (discussed below, 5.5 and 5.6), then O must dialectically necessarily judge S to be competent to exercise his generic right to enabled suicide.

The justifiability of law that is restrictive of the right to enabled suicide on the basis that officials lack sufficient proximity to judge a suicidal PIA's signalling must establish that as regards a particular claim a suicidal PIA's signalled purpose, his 'good reason', or his withdrawal cannot be evidenced to an official. If effective law could not be framed so as to require officials to evaluate the purposes of suicidal PIAs on the basis of insufficient proximity then no category of claimant for enabled suicide could ever satisfy an official that he had a suicidal purpose.

It is beyond the scope of this thesis to delineate specific categories of extreme suffering or competent behaviour that English officials must deem sufficient to satisfy a judgement that a suicidal PIA's condition of extreme suffering has been evidenced and that he has considered it to be a 'good reason' for his suicide. However, if the generic rights of the claimants are to be practically effective, it is necessary to defend the extent to which officials may permissibly doubt the existence of extreme suffering as a reason for the suicidal PIA's lethal purpose. It is submitted that arguments about official incapacity to judge these qualities that are not in bad faith or insincere will exclude spurious possible doubts about competence. The ECtHR, in

Pretty v UK,[24] rejected government arguments that Pretty was not competent to commit suicide, and adverted to her sustained desire to die and her full understanding of her condition in arriving at this determination. It is submitted that the finding on Pretty's competence by the ECtHR should guide the evaluation as to whether official doubts about the reasons and competence of suicidal PIAs are reasonable and not spurious, and this standard is what is generally meant in this thesis by 'reasonable doubts' of officials as to the existence and sufficiency of the signalling and competence conditions of suicidal PIAs.

5.4.5 Reasonable doubts about extreme suffering as a signalled reason: mistake, considered decision, and withdrawal

The dialectically necessary criteria for judging the reasoning behaviour of a suicidal claimant (S), set out above, refer to his evidencing a condition of extreme suffering, evidencing a reasoning process by which he weighs that condition against the continuation his agency as a whole and evidencing his ultimate acceptance of enabling action (including, in some cases, the killing act). It is justifiable to restrict claims where officials cannot demonstrate the existence of these three fundamental aspects of S's judgement beyond reasonable doubt. Thus, reference to the administrative difficulty of securing such official judgements provides a justifiable basis for a hypothetical argument by the UK government that its responsibility to secure the generic right to enabled suicide for such claimants exceeds its minimal responsibility to secure that generic right. This section will therefore examine justifiable official doubts in relation to: *mistake* (5.4.6), or the existence and nature of the condition that the suicidal PIA advances as his reason for suicide; the existence of *considered decisions* (5.4.7) or doubts that the suicidal PIA has sufficiently weighed his condition against his generic interests and considered alternatives; *withdrawal* (5.4.8) or doubts that the suicidal PIA has withdrawn his decision subsequently to signalling to officials (obviously his 'enabler' has failed to respond to this withdrawal and, as such, official doubts about his withdrawal are only applicable where the suicidal PIA does not retain control over the final action).

[24] *Pretty v UK* (2002) 35 EHRR 1 para 73.

5.4.6 Mistake and conditions that are incurable and terminal

If the suicidal PIA is to argue that he has a 'good reason' to commit suicide based on his condition, it is obviously justifiable for officials to establish that the condition exists. A sufficiently considered assessment of his basic generic interests must of course establish that the condition complained of by the suicidal PIA is one that is confirmed beyond reasonable doubt. The existence of a condition that is fundamentally degrading of one's basic generic interests is generally a matter of medical knowledge, and therefore the nature of such conditions is demonstrable beyond reasonable doubt. It is clear that a reasonable medical effort to determine that a condition exists which could then checked by other doctors is manifestly achievable in a country such as the UK; medical staff are trusted with the lives, and deaths, of people in general so it appears inconsistent to doubt their diagnostic abilities only in the instance of a medical assessment of a condition of extreme suffering. For example, officials can be virtually certain that at least some medical assessments of such conditions that are common, such as diagnosing that a patient has reached the final stages of certain forms of secondary cancer, cannot reasonably be doubted.

However, a decisive objection to evidencing a 'good reason' to commit suicide merely on the basis of a medical assessment of a condition can be justified under the above framework where that condition is curable and non-terminal. The framework defined 'extreme suffering' in terms of *agency* to extend to the suicidal PIA's ability, in terms of disposition and opportunity, to *overcome* his condition by reasonable means. The assessment of 'overcoming' in terms of agency referred to his capacity to develop his generic interests to compensate for the condition (see 5.2.4). This means that a reasonably *curable* condition or one that is non-terminal would necessarily raise the possibility that the suicidal PIA did not, in fact, have a 'good reason' to commit suicide on the basis of his condition alone. It is therefore submitted that the complexity of the assessment of the condition creating extreme suffering is therefore qualitatively increased where the condition is curable or non-terminal. However, within the narrow category of conditions that are terminal and non-curable the UK government cannot justifiably argue that officials are unable to establish the condition of extreme suffering beyond reasonable doubt.

5.4.7 Considered decision weighing extreme suffering against agency

It is justifiable to require official assessment to go further than merely enquiring into the existence of a condition of extreme suffering, on the above framework, since the suicidal PIA must also *weigh* his condition against the continuation of his agency. It is therefore reasonably justifiable to exclude 'rubber stamp' decisions where the suicidal PIA presents his reasons as based on his condition of extreme suffering, but does not provide evidence of his reasoning process. The framework therefore does not rule out a possible argument by the UK government that an excessive administrative burden is imposed due to the need for officials to *assess* such a reasoning process. It is therefore possibly justifiable for the government to argue that a general legal proscription upon assisted suicide, essentially the near-absolute prohibition on assisted suicide in law that currently exists, is justifiable on the basis that ensuring that effective safeguards exist would necessitate creating a legal framework for achieving sufficient proximity between officials and the suicidal PIA's reasoning process. As argued above, failure to create such a framework would not *violate* the generic right to enabled suicide. The government's argument on this point in *Pretty* can therefore be sustained under the above framework if the suicidal PIA's reasoning process cannot sufficiently minimise the risk that he has not considered his decision (other aspects of competence such as depression or pressure are considered below: 5.5 and 5.6).[25]

It is beyond the scope of this thesis to set out in detail a defensible legal standard for official evaluation of the weighing of a suicidal decision by a suicidal PIA in terms of his balancing of his condition of 'extreme suffering' against his agency. Fundamentally, the relevant behaviours must convey a 'considered,' as opposed to a reflexive, decision by a suicidal PIA about his *own* generic interests. The signalling must evidence behaviour by the suicidal PIA that conveys his sincere and committed attempt to weigh up his generic interests. It is justifiable to require that the suicidal PIA's enabling action is delayed so that he can evidence that he has had sufficient time and opportunity to conduct such a weighing exercise. English law does, anomalously, permit certain forms of suicidal signalling where the given reason refers to a circumstance that arose only shortly prior to the signalling (i.e. contemporaneous refusals, see chapter 8 and also Samanta and Samanta 2013, 710). There is no single criterion

[25] *Pretty v UK* (2002) 35 EHRR 1 para 74.

of ‘consideredness’ in terms of the opportunity of the suicidal PIA to weigh his decision that could uncontroversially be advanced, other than time, as individuals reason in different ways. However, suicidal decisions are not generally doubted in terms of whether they are a reflexive or ‘rubber stamp’ decision, but rather in terms of the ability of an agent to understand the significance of that decision, which is considered below as regards depressed and pressured signalling (5.5 and 5.6).

The inquest into the death of Kerrie Wooltorton provided a possible illustration of a suicidal purpose that was not considered. In this case Kerrie Wooltorton, who was suicidal, ingested anti-freeze and called an ambulance; she carried a letter signalling her desire to die peacefully in hospital which stated in absolute and all-encompassing terms that she rejected life-preserving treatment (Szawarski 2013, 211).[26] She was, in effect, seeking to exercise a right to suicide which is arguably provided for by English law in the narrow case of refusal of vital treatment (Szawarski 2013, 212; see chapter 8). The letter provided no insight into her reasoning process and she did not suffer from any impairment of her capacity for action. In actuality the hospital staff did know Kerrie Wooltorton’s background and understood that she had a considered wish to die (Szawarski 2013, 211), but if they had not, then reliance on such a signalled choice – with no reasoning behind it – would have failed to establish that the signalled choice had been considered. The prospect of a shallow legalistic response to signalled suicidal choices that could create a chilling effect on efforts to save the lives of (incompetent) suicidal persons is commonly cited as a key objection to permissive reform of enabled suicide (eg Yuill 2013, 129*ff*.). This objection is sustainable under a Gewirthian position, since, as argued below, officials must be sufficiently proximate to the self-reasoning behaviour of suicidal PIAs and no single category for individual reasoning behaviour can be established. However, without addressing competence, it is manifestly counter-factual to assess suicidal PIAs as generally making reflexive decisions; as regards Pretty, for example, it was taken as manifestly evident that she was expressing a considered choice.[27]

5.4.8 Withdrawal

[26] She declined to give any further insight into her reasoning on admission, merely referring to her letter.
[27] *R (Purdy) v DPP* (2009) HRLR 7 (HC).

The justifiability of measures to verify suicidal signalling by official evaluation, as set out in this section, implicitly amounts to a justification for restricting signalling to advance rather than contemporary signalling so that officials have the opportunity to conduct their evaluation, as demonstrated above (see 5.4.3). It is therefore necessarily justifiable for officials to account for the possibility that a choice that is signalled to them might then be withdrawn subsequently, and for procedures to be framed to as to enable them to establish that this has not occurred. Safeguards minimising the possibility of that subsequent withdrawal might not be apparent are necessary to enable officials to be made aware of withdrawals as efficiently as reasonably possible. Unlike a suicidal PIA's *initial* suicidal signalling, evidence of his *withdrawal* of that purpose is necessarily an understandable judgement based on his *positive* evaluation of his generic interests and of continuing his agency (see 5.2.2). The evidential bar for withdrawal of a suicidal purpose is therefore far lower than the high threshold that applies to suicidal signalling (the diametric opposite of that threshold). The suicidal PIA may justifiably be deemed to have withdrawn his decision by *implication* through his conduct and therefore it is justifiable to require official proximity during the signalling process.

The justification for restricting enabled suicide on the basis of withdrawal is only demonstrated where the enabler performs the final action, since withdrawal of a *suicidal* decision is inherent where the PIA retains control over the ultimate killing action. The enabler performs the final action in the "take my life," "end my suffering" situations. In certain "let me die" situations the final action is also taken by the enabler; this occurs where the decision is taken in advance on the basis of future incapacity (see above 5.4.3). As discussed above, the most controversial form that such advanced decisions can take arises where the suicidal PIA has stipulated a future point at which he will be dispositionally incompetent to understand his suicidal decision but remains an ostensible agent (i.e. fairly advanced dementia).

It appears straightforwardly justifiable to restrict enabled suicide by advance decision in cases of long-term dementia – in which the suicidal action would occur long after competence to understand that decision had been lost – on the basis of uncertainty that such a historical decision would still apply, especially after dramatic changes in behaviour and personality engendered by dementia. However, as set out in chapter 8 (see 8.7), English law currently

recognises advanced suicidal decisions for those with dementia (limited to refusals of vital treatment). A possible justification for upholding such advanced decisions was advanced by Dworkin who argued that it was necessary to grant presumptive importance to the 'critical interests' of the suicidal agent who originally signalled the decision, against the 'experiential interests' of the (non-suicidal) current incompetent agent (Dworkin 1993, 229-32). Dworkin famously illustrated this point by reference to Margo, a dementia sufferer who demonstrably enjoyed her life despite the fact that she lacked rational self-reflection (or living 'past reason' in Dworkin's terms (1993, 226)). Despite Margo's current happiness he argued that the validity of a prior advance directive should not necessarily be questioned by officials.

To interpret Dworkin's argument in terms of *withdrawal* (the 'personal identity' objection was considered previously, 5.4.3) under the framework proposed above (see 5.2), Margo could be deemed to be unable to value *preserving her agency*. It is possible to argue that Margo is currently unable to *understand* her suicidal decision and her withdrawal implied by her happy, continued existence, has therefore no basis in reason; this is the converse of her competence to weigh her interests against terminating her agency when she made the advance decision. The judgement that officials must necessarily make is that Margo is incompetent to the extent that she is unable to value her ongoing agency; this is a judgement that she is a *marginal agent*, and is sustainable when a person is in the very final stages of dementia. She is only doubtfully aware of her own purposes in such a state. It is therefore possible to characterise the English position consistently with the above framework as granting primacy to the suicidal advance decision over the preferences of the current (ostensibly) marginal agent and therefore as ruling out withdrawal of her suicidal desire where her agency is compromised to this extent. However, as is discussed in chapter 8, English law permits advance decisions for dementia in a far greater range of circumstances than ostensible marginal agency; it is argued in chapter 8 that the permission for advance directives is strikingly inconsistent in this regard.

5.4.9 Conclusion

The justifiability of safeguards to ensure that an effective signalling procedure has been adopted clearly requires a legal framework to police various categories of evidence of a reasoning process. The administrative burden of framing laws to meet such demands clearly

goes beyond the minimal duty to uphold all claims to a right to enabled suicide that fall within the "take my life" and "help me die" categories. Thus, the overall conclusion about the necessity of the English law on assisted suicide in *Pretty v UK* is confirmed. However, the justification for the above safeguards does not necessarily extend to an *exceptional* procedure to judge competence to commit suicide, as sought by Pretty.[28] The exceptional procedure that established Pretty's considered decision to commit suicide was judicial and necessarily limited, since the courts cannot, without imposing a disproportionately great administrative burden, hear the claims of all potential applicants.

A possible justification that the UK government could advance for excluding all such applicants, even taking account of the possibility of creating such a procedure, as the government argued in *Pretty*, is that there must be proximity between officials and suicidal PIAs in order to judge whether they have considered their signalled decision *competently*, and not withdrawn it. Pretty herself was not depressed nor subject to pressure but, contrary to the argument above as to procedural signalling considerations, it is argued below that such conditions of freedom and self-control are not subject to categorical behaviours that officials generally accept as constitutive of competence. The UK government could argue that the creation of even an exceptional procedure without reasonable assurance that rules could govern competence assessments would result in a 'slippery slope' from allowing the suicide of the demonstrably competent Pretty to accepting the suicide of applicants with marginal competence. The justifiability of imposing such a safeguard encompasses a restriction upon the rights of all the hypothetical claimants and all forms in which these claims could be exercised. The assessment of competence in terms of freedom and self-control conditions is considered below in relation to safeguards against depressed suicide (see 5.5) and pressured suicide (see 5.6).

In addition to a possible exceptional procedure based on *Pretty*, the recognition of certain narrow forms of enabled suicide in English law reveals striking inconsistencies whereby suicidal PIAs receive enabled suicide when they have no time to consider their purpose (contemporaneous refusal of vital treatment) and where they have no ability to control or

[28] *Pretty v UK* (2002) 35 EHRR 1 para 75.

withdraw from the final act (both advanced and contemporaneous refusals). The subsequent chapters will explore these inconsistencies; it will be argued that, while the medical context to this conduct provides a possible indirect justification for such laws, the operation of these narrow forms of physician-assisted suicide is clearly inconsistent with safeguards on enabled suicide (chapters 7 and 8).

5.5 Safeguards against pressured suicide

5.5.1 Introduction

It is justifiable to restrict the exercise of the generic right to enabled suicide under the dialectically necessary framework above in order to establish competence to minimise the risk of pressure (see 5.2.5). An obvious example of pressure arises in the case of a suicidal PIA whose given reason was that his avaricious son would make him suffer if he did not choose to die. It is, however, unlikely that the influencing action would be as straightforward as "die now, or else…". Influencing actions can also be understood as actions designed to achieve a pressuring agent's desired result indirectly by interfering with the PIA's evidenced decision-making process (see above 5.4.7).

The similarity between pressured suicide and murder is recognised under the above framework, but it is argued that an absolute prohibition would rest on an indefensible exaggeration of the difficulty of evaluating a suicidal PIA's freedom from influence. In particular, dialectically necessary criteria can be advanced to direct investigation and disruption of pressuring agents in terms of their proximity to suicidal PIAs. This finding contradicts crude 'slippery slope' arguments that the departure from an absolute prohibition on intentional killing should not be attempted due to the potential to 'slide' from permitted suicide to unwanted killing. Theorised slippery slope arguments seek to make a similar point as regards the 'slide' from suicide within 'safe' limits (in terms of freely chosen suicide) to suicide within 'unsafe' limits. In so far as such arguments adopt a position that there is no standard of behaviour that can be assessed by officials which would indicate that pressure exists, then it is directly contradicted by the framework above. Where such arguments instead seek to demonstrate that the criteria are excessively flexible, it is conceded that this is a valid problem in relation to framing effective law, but that as regards a 'robust' suicidal individual

it is not justifiable to doubt his self-control, except in instances where pressure is exerted upon him by those in a 'close relationship', who are readily identifiable and susceptible to investigation and disruption (if necessary).

5.5.2 Pressured suicide and the 'slippery slope'

The 'slipperiness' of freedom as a condition of competence evaluated by officials, considered also below as regards depression (5.6), is relied on to formulate a powerful and prominent criticism of rights-based reform. The 'slippery slope' is most straightforwardly understood (albeit as an untheorised layman's perception) as the 'slide' into permission for pressured suicide and involuntary euthanasia that, advocates argue, would result from repeal of an absolute prohibition on assisted suicide or voluntary euthanasia (see eg Smith 2013). If this crude expression of the slippery slope was correct then prohibition of euthanasia and assisted suicide would not merely be justifiable under the PGC, but would be *required* for even minimal compliance with the responsibility to secure the generic right to life. There is, however, no defensible basis for arguing that departure from a near-absolute prohibition would transform directly into its opposite – a requirement of involuntary killing. Theorised 'slippery slope' arguments considered in this thesis do not adopt such an unnuanced position (see eg Keown 1995, 262).[29]

There are various theorised 'slippery slope' arguments, but the crux of the most significant sanctity of life-based versions which are considered in this thesis is that rights-based reform of near-absolute prohibitions on assisted suicide are fatally flawed in their own terms, since they cannot adequately defend competence-based legal limits on the availability of assisted suicide and voluntary euthanasia (eg Gorsuch 2006, 91*ff*.; Keown 2012, 148*ff*.). The project of this, and the subsequent section, is to contradict such a claim by demonstrating the dialectical necessity of judgements providing the foundation for criteria to govern official evaluations of pressure. Thus, the implication of such 'slippery slope' arguments, that departure from a near-absolute prohibition would necessarily violate the generic right to life

[29] A prevalent sanctity of life argument is that departure from an 'absolute' prohibition on intentional killing would *indirectly* result in a society that devalued the life of its vulnerable members including, possibly, coercing such vulnerable people to end their lives prematurely (Finnis 1995, 23-24).

by permitting 'pressured' suicide, is rejected. The next section will address what is argued to be the most powerful 'slippery slope' argument, which is that official evaluations of depressed signalling lack definable criteria and thus, that if such evaluations are to be sufficiently proximate, procedures must enable officials to judge suicidal PIAs in a *flexible* manner that is *oriented towards individual PIAs* (see below 5.6; see as regards framework and competence, 5.2.3, 5.2.5).

5.5.3 Necessity of excluding risk of direct coercion or influence

It is straightforwardly justifiable to require that a suicidal decision is free from direct restraint or influence by another. Apparent direct influence entirely contradicts the judgement that a suicidal PIA's action is 'signalling' a suicidal choice. On the framework above, the possibility of direct coercion *must* be excluded since coerced signalling is not evidencing such a choice. Procedural safeguards that exclude this possibility are therefore obviously justifiable, but this does not provide the UK government with an argument that a near-absolute prohibition on assisted suicide is justifiable since excluding coercion is straightforwardly achievable by direct official review of the suicidal PIA's signalling. These safeguards are already stipulated in English medical guidance and are required for valid consent in law (eg GMC 2008 para 41; Pattinson 2002b; see further chapter 8).

An illustration of a case of direct influence is provided by *Re T*[30] in which the patient had the suicidal purpose of refusing a vital blood transfusion (see further, 8.5). There was evidence that the patient's mother was determined that her daughter would refuse the vital treatment on the basis of her religious beliefs[31] and directly acted to 'encourage' her daughter to do so.[32] In particular, the mother was alone with her daughter immediately prior to the signalled decision to refuse[33] and there was evidence that she had discussed the subject of refusal of a blood transfusion.[34] The case is somewhat complicated by the fact that the mother's desire was to encourage her daughter's resolve to die according to her *daughter's* values; however, it is

[30] *Re T* [1992] WLR 782.
[31] She was an orthodox Jehovah's Witness who accepted the biblical prohibition on ingesting blood as applied to prohibit modern blood transfusions (Watchtower 2008).
[32] *Re T* [1992] WLR 782.
[33] *Ibid,*118.
[34] *Ibid.*

clearly defensible for officials to reasonably doubt that such direct encouragements could amount to pressure compromising a suicidal PIA's competence. This is because there is a fine distinction between such encouragement and pressure, and relevant officials (a doctor in that case) are clearly justified in prohibiting either action rather than attempt to distinguish between the two, at least during or directly before the suicidal PIA's signalling. Furthermore, the daughter was not merely signalling acceptance of assistance which she would then control, but a medical procedure that was entirely in the control of the enabler (see above 5.4.2).[35]

5.5.4 Necessity of minimising risk of influence by investigating those close to the suicidal potentially incompetent agent

It is justifiable for English law to require officials to assess the suicidal PIA's competence beyond freedom from coercion at the point of signalling, since it is, of course, reasonably possible that a suicidal PIA's apparently free quiescence could be directed by another at a distance. Therefore, officials must go beyond signalled reasons to determine whether others are influencing that person; thus, it is necessary to advance criteria to determine *who* it is reasonable to investigate. It is not reasonable to doubt everyone who possibly has any degree of capacity and opportunity to influence the suicidal PIA's signalled decision. It is argued that only those in a *close relationship* with the suicidal PIA should reasonably be judged to have the opportunity and capacity to affect the suicidal PIA's competence to arrive at a self-regarding suicidal decision. However, there is a crucial qualification to this limitation in that the PIA who is 'depressed', or a non-robust suicidal self-reasoner, can reasonably be judged to be susceptible to pressures from others with whom they are not in such a close relationship. The justifiability of safeguards to exclude pressure is therefore not distinct from the justifiability of safeguards to exclude depression; as discussed in the next section, the intersection between depression and influence is the strongest basis for arguing that reform based on giving effect to the generic right to enabled suicide within initially narrow competence safeguards could 'slip' so that claims which could justifiably have been restricted

[35] The case involved a successful argument of undue influence in the context of suicidal refusal, but this is not relevant to the current analysis (see further 8.5).

initially are accepted by subsequent reform. However, this section addresses pressure exerted upon 'robust' suicidal PIAs only.

It is justifiable to investigate possible pressuring agent (Z) as regards a suicidal PIA's (S's) signalled purpose only where Z reasonably possesses the capacity and opportunity to influence S – which is where he is in a 'close relationship' with S. It was demonstrated in the above framework that pressure cannot therefore reasonably be judged to exist outside a relationship that involves *proximity* between the influencer and the suicidal PIA *as agents*. This judgement is partly one of straightforward physical or temporal proximity, but it cannot rationally be restricted to that; a 'close relationship' must also encompass a judgement about the ostensible proximity between S and Z, such that Z can engage with and override S's will (see above 5.2.5). The physical and temporal proximity of the influencer to the suicidal PIA during signalling is straightforwardly judged, although it is not reasonable to set out any particular measurement in absolute terms.

An illustrative example of proximity between influencer and a suicidal PIA is provided by the case of George Delury, who was successfully prosecuted for second degree homicide of his suicidal wife; he facilitated her suicide by procuring a lethal substance and completed her suicide attempt by suffocating her (Delury 1999, 178). His wife Myrna, who suffered from multiple sclerosis, lived with her husband. Therefore, on this ground, it would have been reasonable to judge him to have the capacity to influence her; however, it is not reasonable to base capacity to influence *solely* on physical and spatial proximity.

The justifiability of reasonable investigation of pressure upon the self-reasoning of 'robust' suicidal PIAs must encompass capacity and opportunity to pressure in terms of *proximity of agency*. The above framework defined this concept as the capacity for an influencer to control the suicidal PIA's generic interests for his own ends (see above 5.2.5). A paradox is thus created whereby dependent people who have a 'good reason' to commit suicide are generally also dependent on care and support, and such carers are necessarily in the position of being capable of bringing pressure to bear on the PIA's decision in favour of suicide. A

close relationship of care and support obviously existed between Pretty and her husband[36] and Purdy and her husband,[37] although in both cases it was evident that the capacity to influence was not exercised by their husbands who were evidently supportive. It also existed in contrast in the case of George Delury: certain family members alleged that this capacity was exercised for George's own ends (Delury 1999, 183*ff.*).

Another common context in which a potential influencer has the capacity to control a suicidal PIA's generic interests for his own ends necessarily occurs where the PIA is in the care of a medical professional (see also as regards medical undue influence eg Pattinson 2002b; Beyleveld and Brownsword 2007, 169-70). This is because a medical professional in certain forms of treatment-based relationships is necessarily granted control of her patient's basic generic interests. Accusations of the exercise of such influence occurred in the case of *R v Adams*[38] in which a doctor who had facilitated the deaths of a number of elderly patients, was unsuccessfully prosecuted (Robins 2013, 77).[39] In particular, he was accused of exercising influence over a suicidal patient Gertrude Hullett, for whom he was prescribing strong barbiturates. Dr Adams was not attending the surgery when she attempted suicide and fell into a coma; as was heavily implied in the evidence leading up to his trial for murder, he was forced to lie to the attending physician as to the likely cause of her condition, barbiturate poisoning, which frustrated the efforts to save her life (Robins 2013, 53*ff.*). Obviously Adams' actions were contrary to the law on assisting suicide (then prior to the 1961 Act), but what is relevant to the extant analysis is that Dr Adams received £3900 from Gertrude, both through a cheque cashed immediately prior to her death and in her will by acquiring her Rolls Royce (combined current value £120k). Dr Adams' questionable character and obvious motivation to enable the patient's suicide were clearly incompatible with the exercise of his 'caring' role. The separate question whether he had exercised this capacity for influence was not proven, and the jury did not accept the prosecution's case as regards murder (see further 8.5).[40]

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[36] *R (Pretty) v DPP* (2001) EWHC 788 (HC).
[37] *R (Purdy) v DPP* (2009) HRLR 7 (HC).
[38] *R v Adams* [1957] Crim L R 773.
[39] An infamous and extremely significant case for English medical law (eg Pattinson 2014, 14-017).
[40] *R v Adams* [1957] Crim L R 773.

The justifiability of safeguards against pressure provides a broader justification for restriction upon enabled suicide than direct coercion, but there are definable limits to pressure on the dialectically necessary framework proposed. However, a degree of flexibility and sensitivity by officials would be required when investigating those close to suicidal PIAs and if necessary preventing possible influence; a mechanical application of rules governing such pressures would be counterproductive if the suicidal PIA was forced to contemplate his suicide alone. An official's interference with those in a close relationship to a suicidal PIA could readily amount to disruption of the very self-affirming relationships that supported him to come to his decision in the first place. The importance of those close to a suicidal PIA in terms of *supporting* his competence is self-evident, especially where they are suffering, as illustrated by the cases of Pretty and Purdy. In Purdy's case in particular it was clear that her timing and manner of death depended directly upon excluding the possible interference with her husband by officials.[41] It is therefore justifiable to argue that there is a degree of administrative burden created by official proximity necessary to distinguish between whether a relationship is *supporting* as Pretty's husband evidently was or *pressuring*, as Dr Adams possibly was.

5.5.5 Conclusion

A suicidal PIA's competence to advance his 'extreme suffering' as a reason for his decision, requires him to be free from pressure that interferes with his self-control; thus, in order to secure the generic right to suicide to any of the hypothetical claimants necessitates a degree of proximity between officials and suicidal PIAs beyond evidence that a reasoning process had occurred (discussed as regards signalling above, 5.4.5). It is straightforwardly justifiable to require safeguards against apparently pressured signalling; indeed, the essence of protection of the generic right to life is the protection of free agency (see previous chapters, eg 2.6 and 4.3). Furthermore, officials must achieve proximity with the unpressured self-directed suicidal purpose of suicidal PIAs and those in close relationships to them. The possibility of influence by others who are not in a close relationship with the suicidal PIA is considered below as regards depressed signalling, since the definition of 'depression' adopted

[41] *R (Purdy) v DPP* (2009) HRLR 7 (HC) [4].

encompasses lack of self-esteeming suicidal behaviour in its own right, rather than addressing subtle undermining influences as forms of pressure.

5.6 Safeguards against depressed suicide and the slippery slope

5.6.1 Introduction

The framework for official judgements as to the competence of suicidal PIAs (set out above, 5.2) demonstrates that depressed suicidal purposes, understood as 'self-oblivious' suicide, may justifiably be deemed to be incompetent and that an official empowered to interfere may therefore permissibly do so. The justifiability of restrictions upon a suicidal PIA with 'severe' depression was assumed, since he is clearly below the high level of self-regard necessary to be judged competent to weigh his generic interests against the continuation of his agency (see as regards mental health and competence generally, Beyleveld and Brownsword 2007, 110). It is argued that there is no uncontroversial dialectically necessary criterion of self-regard that translates into externally evidenced forms of behaviour in order to provide a foundation for official judgements. The lack of definable criteria justifies restriction of enabled suicide on the basis of the potential for a 'slippery slope' towards toleration of depressed suicide, but such a risk does not justify absolute prohibition.

5.6.2 The 'slippery slope' and behaviours indicative of depression

The justifiability of restricting the right to enabled suicide, particularly to those who are suffering, forms the basis of a powerful objection to rights-based legal reform. It is argued by opponents of such reform that Pretty and Purdy, as suicidal claimants, are unrepresentative (Keown 2002, 192; 2012, 152*ff*.) and that most 'ordinary' people with conditions of extreme suffering cannot be considered to be self-esteeming agents (eg Huxtable 2007, 18-20; Keown 2002, 87, 109, 131). From that perspective the possibility of rights-based reform is therefore criticised on the basis that it would ultimately accept that incompetent suicide would be permitted, which exceeds its justificatory basis (eg Gorsuch 2004, 1395-6). It is argued that the dialectically necessary framework cannot entirely meet this criticism since it cannot propose generically definable criteria to guide an investigation of depression, unlike the criteria proposed above for pressured suicide. However, it is argued that a minimum level of

behaviour necessary to guide official evaluations can be identified and therefore that the English near-absolute prohibition on enabled suicide cannot be entirely justified on the basis that departing from it would result in tolerance of depressed suicide.

An expansive definition of dispositional competence is justified on the above framework. This definition extends to 'mild' as well 'severe' depression (see above 5.2.5). It was argued that the definition of 'mild depression' could encompass a 'robust self-reasoner' standard for the suicidal PIA's behaviour. In addition to such a standard for dispositional depression, it was argued that occurent depressive behaviour encompassed a standard of rationally considered self-regarding decision-making rather than emotional decision-making, such as one based on a 'feeling of despair'. These standards are not susceptible to exhaustive definition; the suicidal PIA's behaviour should indicate that he is capable of valuing his generic interests and taking them into account so as to judge his self-worth 'fairly' at his current or predicted level of purpose fulfilment. It is beyond the scope of this thesis to define mild depression further in terms of particular behaviours; it was suggested above that 'courageous,' 'self-reliant,' 'temperate' behaviours indicative of self-assertion would indicate competence, while 'timid,' 'impulsive,' 'dependent' behaviours are indicative of 'self-passivity'.

The relevant behaviours of self-assertion and self-passivity do little to illuminate *what* is being measured and *how* it could be measured. The lack of definite content to such measurements may be contrasted with the measurements of 'extreme suffering' which are susceptible to evidence by medical assessment (see above 5.4.6). The measurement of 'depressed' reasoning behaviour is, rather, determined by conventional ideas of the behaviour of 'ordinary' persons (albeit subject to a criterion of self-regard that is derived from the PGC). Furthermore, the measured behaviour lacks an obvious 'expert' associated with it, especially in the context of a *suicidal* desire; a psychological analysis would undoubtedly be of benefit for the measurement of such behaviours but the expert's analysis cannot provide the certainty that a medical oncologist could as regards certain conditions of 'extreme suffering'.

To illustrate the relevant standard it is useful to refer to a case of enabled suicide in a country that has legalised it. An extremely controversial recent case from Belgium concerned the

euthanasia of Nathan Verhelst, a transsexual man who sought euthanasia shortly after transitioning (Bioedge 2013). He desired suicide due to the unbearable emotional suffering brought about by, in his terms, a life-time of neglect, gender identity dysphoria and the destruction of his hopes for a 'cure' by his failed transitioning (Telegraph 2013). The basis for his enabled suicide was 'emotional suffering' (in Belgian law) and before he died the emotional basis of his decision became evident in an interview in which he conveyed the emotional devastation that he experienced when the operation not only failed but, in his view, turned him into a 'monster' (Huffington Post 2013). The case appears, at face value, to be one which is clearly contrary to the notion of competence under the dialectically necessary framework above, since Verhelst's behaviour straightforwardly contradicts conventional notions of a self-esteeming agent, and instead conforms to the familiar conception of suicide as an act born of self-hatred. It is certainly far from clear that Nathan's suicidal purpose was born out of self-esteem, as Purdy's was, but a closer examination reveals subtle factors both against and in favour of finding Nathan to have been competent as a self-regarding agent.

A hypothetical judgement on Nathan's case requires an assessment of his competence to advance his transsexualism and failed transition as a condition of 'extreme suffering' and a reason to end his agency (accepting for the sake of argument that such a condition can amount to 'extreme suffering'). A precise account of Nathan's behaviour is not possible and is unnecessary, but it is clear that there are a number of problematic factors in terms of his competence. His transsexualism exposed him to emotional abuse from his family and society that is associated with low self-esteem and severe depression. Statements that he made to the media before his suicide confirm the emotional abuse he faced from his family and from society for his condition (Huffington Post 2013). Finally, his gender dysphoria and the immediate reason for his suicidal purpose, his failed transition, would indicate that he would find it difficult to weigh his gender dysphoria fairly against his other generic interests. Against these factors, there are some indicators in favour of Nathan's competence. Nathan's long struggle with his condition and his attempts to address it with surgery arguably evidence his prior determination to value his agency. Similarly, his suicidal desire stemmed from a failed attempt to *live on his terms* by seeking surgery, which is not the action of a self-disregarding agent. Finally, Dr Distelmans, who administered the lethal injection, confirmed that Nathan's decision was not because he was 'tired of life' – but rather was due to a struggle *to live* which Nathan had come to feel was beyond him (BioEdge 2013).

The competence factors relevant to an evaluation of Nathan's enabled suicide present a clash between notions of self-esteem as emotional dispositional/occurent competence, and the contrasting characterisation of self-esteem evinced by an agent struggling to value his purposes and overcome his condition. Nathan's experience of emotional abuse would mean that an official could justify a finding that Nathan did not value his agency to others, but Nathan's struggle equally indicated that his life is characterised by self-assertion to an extent, since he had valued his purposes sufficiently to take actions which could have enabled him to value his life on his terms. Ultimately, neither emotional nor agent-based indicators of self-esteem should be viewed as decisive, and a final judgement cannot be given at a distance on the basis of such conditions. The behaviours of self-assertion and self-passivity merely contextualise an *individual assessment* of Nathan by an official judging him as an agent on the basis of his current suicidal purpose. It is argued below that reform based on such an assessment, while 'slippery', is necessarily achievable by agents and is within the UK government's capacity and responsibility, but that the administrative burden of doing so must be taken into account in terms of finding a violation of the generic right to enabled suicide of hypothetical claimants.

5.6.3 A proximity-based assessment based on Pretty v UK

The 'slippery slope' argument is correct in so far as behaviours indicative of depression are both crucial to the justifiability of restrictions upon enabled suicide and are not susceptible to an exact definition. Nevertheless, the claim that a near-absolute prohibition that is *certain* to frustrate the freedom of at least some suicidal PIAs is also not defensible. It is submitted that a sufficient basis for the competence assessment is provided by the seminal *Pretty* case in which the courts found the applicant to be competent (see chapter 3). By this it is not, of course, meant that all applicants must meet her standard of determination and pursue their case for suicide through the stages of national and international courts, but that the basis for that judicial assessment of competence, in terms of proximity between the judges and Pretty *as agents*, was key to their assessment. The relevant degree of engagement between an official and a suicidal PIA (S) requires each as individual agents to learn to understand the other and thus for S to engage with O's (the official's) self-reasoning in order to learn how to communicate to O the necessary quality of his self-regard. It is therefore argued that

safeguards against allowing depressed enabled suicide are 'proximity-based' and it is justifiable to require *direct proximity* between a judging agent and a suicidal PIA. As discussed above, such direct proximity is, however, both administratively burdensome and individually burdensome to individuals (see 5.2.3).

It is argued that a limited analogy may be drawn between an official's judgement of a suicidal PIA's self-regarding purpose and a jury trial in a murder case seeking to establish the intention of the defendant. In such a trial the jury can hear expert witnesses who seek to demonstrate the quality of the defendant's intent beyond reasonable doubt, and judicial framing of jury directions can isolate the crucial behaviour evidencing intent that they should judge. However, it is fundamentally their capacity as *agents* to understand the 'intending' behaviour of the defendant that must be appealed to in terms of their competence to decide his guilt. Their reasonable attempt (assuming that they not responding in a purely emotional fashion) to engage with the defendant's purpose, as agents, knowing that their judgement condemns him, as an agent, to the basic harm of loss of liberty (and life in certain states in the US), grants them such competence. To apply this analogy to O judging S – she can hear expert evidence, the 'testimony' of S and those close to him, and frame the question to herself as to the status of S's self-regard. However, she must rely on her ability as an agent if she is to judge a fellow agent's purpose, knowing that her assessment leads to effectuating the choice between his possibly incompetent suicide or the continuance of a life whose value he has potentially rejected.

5.6.4 Conclusion

The lack of uncontroversial generic criteria to frame safeguards against depressed suicide provides a foundation for the justifiability of legal rules requiring official interference with *all* the hypothetical claims to the generic right to enabled suicide, regardless of the form which the exercise of the right takes ("take my life" etc in 1.3.3; see also above 5.4.2). It is therefore argued that even an exceptional procedure would not be immune to reproach, and, indeed, that an officious or distant legal response, if that was the result of legalisation, would ultimately fail to value agency. It is therefore argued that the sanctity of life-based 'slippery slope' argument considered above is not indefensible as a basis for English law, albeit with the significant qualification that official assessment of a suicidal purpose must be deemed to

be *possible* (see also 5.5.2). It is submitted that the UK government can justifiably argue on this basis that it does not violate the generic rights of all categories of claimant who currently cannot receive enabled suicide under English law due to the lack of a generally applicable legal framework designed to determine their competence.

However, it does not follow that it is the case that a blanket prohibition is necessarily defensible. The provision of at least an *exceptional judicial procedure* by which officials can directly assess signalling in order to minimise the risks of depressed and pressured signalling is clearly not beyond the UK's minimal responsibility under the generic right to enabled suicide (see above 5.5). This is a key aspect of the argument in the next chapter as regards English law in which the creation of such an exceptional procedure was advocated by certain of the Supreme Court Justices in *Nicklinson*.[42]

5.7 Conclusions

The PGC requires that the proportionality of English law on assisted suicide and voluntary euthanasia must be judged in terms that are defensible in terms of agent-rights, as established in the previous chapter. It has been demonstrated that the findings of the ECtHR in *Pretty* as to the proportionality of English restrictions on assisted suicide,[43] interpreted in accordance with the above framework, possess a definable minimum content. In terms of the hypothetical claimants, the UK government can advert to the necessity of safeguards on certain bases, related to *forms* of signalling, enabling actions and possibility of pressure but, as regards all claims, it can be justifiably argued that safeguards are necessary to minimise the risk of depressed suicide. The application of the above framework to English law has revealed some striking inconsistencies when various voluntary life-ending phenomena are defined as enabled suicide, especially as regards refusal of vital treatment. The basis for such inconsistencies, in terms of disputed distinctions and the sanctity of life are discussed in the subsequent chapters. The framework in this chapter provides the basis for evaluating the resulting inconsistencies created by such rules. It will be argued that English law is indirect and evasive, and thus breaches the principles of a good faith, sincere and committed attempt

[42] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [314].
[43] *Pretty v UK* (2002) 35 EHRR 1 para 74.

to apply the PGC in many respects. This evaluation will provide the basis for considering forms of minimal and more extensive legal reform in chapters 9 and 10.

Chapter 6: English law affecting "take my life" and "help me die" claims

6.1 Introduction

The primary analysis in this chapter relates to legal challenges to the near-absolute prohibition on assisted suicide in English law by claimants seeking enabled suicide. The chapter also considers, as the context to such claims, the legal sanctity of life basis for the prohibitive stance. The role of Article 8 ECHR, as discussed in chapter 3, is developed in detail as the basis for legal challenges (under the Human Rights Act 1998). The compatibility of English law on voluntary euthanasia[1] and assisted suicide with Article 8 has been recently litigated in the Supreme Court in the *Nicklinson* case.[2] This litigation raised many points relating to the interpretation of the domestic right in *Pretty v UK*,[3] as applied to the claimants. The discussion of safeguards limiting a generic right to enabled suicide in chapter 5 will be relied on to evaluate the findings in *Nicklinson* as to means of protecting 'the vulnerable'.

It is necessary to distinguish between the domestic interpretation of the Convention right to choose the manner and timing of death recognised in Convention jurisprudence (see 3.4.3) and the *justified* interpretation of that right under the PGC. It is therefore useful, in terms of clarity of presentation of the analysis in this chapter, to focus on domestic judicial interpretations of the 'Article 8 right to dignified suicide' and then proceed to evaluate such interpretations, and English law in general, under the generic right to enabled suicide.[4] The term 'Convention right to enabled suicide', as was discussed in chapter 3, which was a Gewirthian interpretation of that right as a human *agent* right, is therefore *not* adopted in this chapter (in the subsequent chapters evaluation is conducted under the *generic right* to enabled suicide, rather than under the Convention right to enabled suicide). The differences between domestic interpretation of the Article 8 right and the generic right to enabled suicide, especially as regards proportionality, are argued to be an important feature in the judicial reasoning in *Nicklinson*. In particular, it will be suggested that these differences partly

[1] The minor distinction between 'suicide' and voluntary euthanasia in a narrow medical context was raised by the Supreme Court in *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [227] per Lord Mance.
[2] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200.
[3] *Pretty v UK* (2002) 35 EHRR 1.
[4] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [56].

undermine *Nicklinson* as a basis for reform of English law towards recognition of the generic right to enabled suicide to extent. Nevertheless, the possibility of future, direct and *substantive* protection for the Article 8 right to dignified suicide is obviously a significant development in the direction of accommodation of the generic right to enabled suicide. This has already occurred, to an extent, in the form of impetus for and guidance to the Committee stage of the Assisted Dying Bill 2014-15[5] (November 2014) coming from *Nicklinson*.[6]

This chapter will firstly briefly consider the sanctity of life principle as a foundational principle of the near-absolute prohibition on enabled suicide in English law; this overview of the sanctity of life as a legal doctrine, expanded upon in subsequent chapters, provides the context for the discussion of legal rules prescribing interference with the hypothetical claims (see 6.2). That will provide the backdrop for the consideration that follows of the legal restriction upon hypothetical "take my life" claims, as raised by the common law-based arguments in Nicklinson and Lamb in the *Nicklinson* litigation (see 6.3). The discussion of the Court of Appeal decision in *Nicklinson* below is largely concerned with the possibility of the development of the common law defence to murder in the enabled suicide situation, while in strong contrast the discussion of the Supreme Court decision in that case is concerned with the compatibility between an Article 8 right to enabled suicide and s2(1) of the Suicide Act.

Before considering the Supreme Court decision in relation to two of the claimants, Nicklinson and Lamb, the chapter will turn to legal restrictions upon hypothetical "help me die" claims which are analysed in light of the recent challenges to the offence of assisted suicide by claimants seeking exceptional relief from the Suicide Act 1961 s2(1) (which provides the basis for such restrictions). This analysis will include examination of the seminal *Purdy* case,[7] which first recognised the Convention right to control the manner and timing of death (the right to dignified suicide as interpreted domestically), stemming from *Pretty v UK*, as applicable to English law on assisted suicide (6.4, 6.5; see also 3.6.3). As discussed in 3.6.3, the *Purdy* decision created the basis for the procedural recognition of the Article 8 right to dignified suicide which also led to the creation of the DPP's February 2010 guidelines on

[5] HL Deb Col 1852, 7th November 2014.
[6] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200.
[7] *R (Purdy) v DPP* [2009] UKHL 45.

prosecution of assisted suicide (DPP 2010; see 6.5). 'Procedural recognition' in this context refers to transparency as to prosecution policy in instances of assisted suicide. The analysis of procedural recognition of the Article 8 right to dignified suicide will encompass the recent decision in *Nicklinson* as to applicant Martin, whose claim was based directly upon Purdy's and which resulted in the recent revisions to the Guidelines (in October 2014).

Having discussed procedural recognition of the Article 8 right to dignified suicide, the chapter will then turn to the substantive proportionality analysis in *Nicklinson,* related to Nicklinson and Lamb which, it will be argued, is the most significant aspect of the judgment for future recognition of the generic right to enabled suicide (see 6.5). The general background and outline of the analysis in *Pretty v DPP* is examined first and, in particular, the initial approach of the domestic courts to Pretty's Article 8 right to dignified suicide is briefly touched upon (see 6.6). This analysis will provide the background to the discussion of the current approach of the domestic courts to the issue of substantive proportionality in *Nicklinson,* which, it is argued, is crucial to future recognition of a legal right to enabled suicide in English law, both judicially and legislatively (6.7).

6.2 The sanctity of life, euthanasia and assisted suicide in English law

The principle of the sanctity of life[8] has long been recognised as a fundamental legal doctrine which was advanced historically as the basis of English common law prohibiting suicide, assisted suicide and euthanasia (eg Gorsuch 2006, 28*ff.*).[9] Lord Hoffman in *Airedale NHS Trust v Bland* (1992) (CA)[10] defined this doctrine as follows:

> … the sanctity of life entails its inviolability by an outsider. Subject to exceptions like self-defence, human life is inviolate even if the person in question has consented to its violation.

[8] The sanctity of life position, which purported to find a cohesive principle restricting 'intentional killing' regardless of quality of life, was discussed in 2.4.
[9] Lord Steyn emphasised the historical importance of the doctrine in *R(Pretty) v DPP* (2001) (HL) 825 [54].
[10] The case is unreported; it is cited by the House of Lords in *Airedale NHS Trust v Bland* [1993] AC 789,831.

The doctrine, in this form, appears clearly contrary to the existence of a human right to enabled suicide, as discussed in chapter 2 (see 2.4); however, as discussed in the previous chapter, laws requiring interference with suicide are potentially justifiable in the absence of a general scheme of effective safeguards against incompetent suicide under the UK government's minimal duty to secure the right (see 5.4-5.6). Furthermore, the sanctity of life principle in English law has been interpreted so as not to extend to official interferences with enabled suicide (as defined in this thesis) in the narrow instance of life-shortening treatment. The basis for this is a theorised sanctity of life position which recognises the doctrine of double effect, discussed in chapter 2 (see 2.4.2). As is discussed in chapter 7, this doctrine forms a possible basis for an "end my suffering claim" since the suicidal claimant (S) and doctor enabling his suicide (E) can establish that officials empowered to interfere (O) will not do so if E acts to relieve suffering and lacks the 'intention' of killing S.

The theorised sanctity of life position described in chapter 2 (at 2.4) finds that *life* is inviolate which, on this view, entails the (moral) impermissibility of both suicide and assisted suicide. English law does not adopt this position. The framing of the sanctity of life principle by Lord Hoffman in terms of inviolability by an *outsider* above is compatible with the English permission for suicide (Suicide Act 1961 s1) and prohibition of voluntary euthanasia and assisted suicide.[11] An alternative possible interpretation for the position adopted in s1, compatible with the theorised sanctity of life position, would be that there is no public interest in prosecuting or imprisoning those who seek to commit suicide and therefore the legal duty to punish suicide has been disapplied, but that those under a duty of care (eg doctors, prison officers) may have a legal duty to interfere with suicide.[12] This latter position retains a degree of support,[13] but English law in relation to doctors has moved decisively towards non-interference in suicide in the decades after the Suicide Act; this development was ultimately accepted by the House of Lords in *Bland*.[14] The theoretical weaknesses of the English sanctity of life doctrine is evident in the medical context where physicians exercise a

[11] The creation of an offence of *attempt* where the action abetted was not criminal was unprecedented, but the courts confirmed assisted suicide as an offence of attempt at common law in *R v McShane* [1997] Crim LR 737.
[12] See eg per Lord Bishop of Carlile in the debate on the Suicide Bill 1961 HL Deb Vol 229 Col 258, 2nd March 1961.
[13] On the basis that they deserve society's compassion rather than its censure eg Hl Deb 2nd March 1961 Vol 229 Col 258 per Lord Bishop of Carlile.
[14] *Airedale NHS Trust v Bland* [1993] AC 789.

significant degree of control over the continuation of the lives of patients; this control is generally accepted as creating an uncertain distinction between non-interference with and assistance in suicide in this context (see eg per Lord Goff in *Bland;*[15] Livings 2010, 33). The law has arrived at a position whereby certain forms of "let me die" claims can be exercised *directly* in English law by requiring that an 'enabler' does not act to interfere with suicide by providing a life-preserving device.

A legal 'exception' to the sanctity of life-based proscription of active assistance in suicide in favour of a doctrine of patient self-determination has been recognised in the medical context,[16] the development of which is a result of the uncertainty created by the English sanctity of life doctrine discussed above. The exception applies even where a patient's refusal must be effectuated by an action which occurs where the patient requests the withdrawal of a life preserving device[17] (a treatment, or a clinically assisted vital function; see 8.2). The "let me die" claim also falls within this exception, and therefore *acts* of assistance in suicide receive limited direct recognition in English law, despite the prohibition on such acts in the Suicide Act 1961 s2, on the basis that such acts giving effect to refusal are, in law, omissions. The remaining limits on the "let me die" claim and proscription of forms of enabled suicide are argued to be particularly anomalous in light of the 'exception' to the prohibition on assisted suicide for withdrawal of treatment (see further 8.2; see also 5.4.2). This chapter does not consider these 'exceptions,' however, and will instead address legal challenges to the general restriction on enabled suicide in relation to the "take my life" and "help me die" claims.

6.3 English law on murder and the "take my life" claim

It is worth restating the "take my life" claim (set out in 1.3.3), where S is the suicidal claimant, O is an official empowered to interfere, E is the person enabling the suicide:

[15] *Airedale NHS Trust v Bland* [1993] AC 789, 865.
[16] *Re B* [2002] EWHC 429; see 8.2.
[17] *Ibid.*

> S wants to end his life but cannot due to being physically incapable of doing so. He claims that O should not interfere when E kills him on his request.

Euthanasia is prohibited by the English common law offence of murder, so an official (O) under a duty to enforce the law, such as a prosecutor, is required by English law to interfere with E's action in 'killing' S by enabling him to carry out his suicidal purpose in the "take my life" claim. In the *Nicklinson* case in the High Court and Court of Appeal, Nicklinson and Lamb argued that in their circumstances their killer should be able to benefit from a defence of necessity. (The applicants in the Supreme Court were in fact not Mr Nicklinson, who died shortly after the High Court decision, but Mrs Nicklinson, and Lamb, an applicant in the same position as Nicklinson who was permitted to continue Nicklinson's original claim).[18] Lamb's circumstances are described as follows:

> [Lamb] is completely immobile with the exception only of his right hand which he can move to a limited extent. He requires constant care and has carers with him, funded by the local Primary Care Trust, 24 hours a day. He spends the whole of every day in his wheelchair. He experiences a significant amount of pain every day and has done ever since the accident, with the consequence that he is constantly on morphine. He feels that he is trapped in his body, and that he cannot enjoy or endure a life that is so monotonous and painful and lacking in autonomy. His condition is, at least in the present state of medical knowledge, irreversible. He wishes that a doctor should end his life.[19]

In the Court of Appeal Lamb argued that the common law defence of necessity should be developed so that in his limited circumstances another's action enabling him to die by performing the final killing act, voluntary euthanasia, would be deemed to fall within the defence.[20] The argument as to development of a common law defence of necessity was not related to the Article 8 ECHR right to 'dignified suicide' under the HRA, but relied instead

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[18] Nicklinson's claim as regards developing the common law defence of necessity (see below this section) lacked 'practical significance' (*R (Nicklinson) v Ministry of Justice* [2013] EWCA Civ 961 [13]).
[19] *Ibid* [14].
[20] *Ibid* [38].

upon fundamental common law principles of autonomy and dignity. This approach was condemned as misconceived by the Court of Appeal, since the common law principles, as they applied to Lamb, merely echoed his Article 8 right to dignified suicide, but without the additional support of the HRA.[21] Furthermore, the Court of Appeal unanimously observed that the 'right to autonomy' or 'right to dignity' could not necessarily be viewed as concrete common law rights as opposed to principles informing the law.[22]

The Court of Appeal was unanimous as to the difficulty of addressing concerns as to balancing the purported rights against public interests that would be created by recognising common law rights to autonomy or dignity. In particular, the Court sought to uphold the common law principle of the sanctity of life, and was concerned as to the risk posed to vulnerable people who might feel pressured into undergoing euthanasia.[23] It was found unanimously that the questions of morality and evidence were overly complex for the Court to address; Toulson LJ's initial decision in the High Court[24] that the common law should not go beyond legislation by crafting a defence of necessity was approved.[25] Lamb sought to argue that the judges should accept that the common law was irrational and arbitrary in restricting his purported rights, since refusal and *withdrawal* of vital treatment were permitted (see further chapter 8 as regards the legal response to the "let me die" situation); he argued that Toulson LJ's objections to changing the common law in terms of 'competence, constitutionality and control of the consequences' did not address this concern as to irrationality.[26] However, the Court of Appeal found that the distinctions complained of were 'deeply rooted in the common law,' and did not accept that the distinctions thus created were manifestly irrational; the assessment as to whether they were so was deemed to be beyond the competence of the Court.[27]

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[21] *Ibid* [49].
[22] Lamb referred to the comments by Lord Hoffman in the Court of Appeal (referred to in the House of Lords in *Airedale NHS Trust v Bland* [1993] AC 789, 826) concerning the 'principle of autonomy'; it was emphasised that in the House of Lords decision the recognition of a concrete right was far from established eg per Lord Goff (*ibid* 864).
[23] *R (Nicklinson) v Ministry of Justice* [2013] EWCA Civ 961 [14], [54].
[24] *R (Nicklinson) v Ministry of Justice* [2012] EWHC 2381.
[25] *R (Nicklinson) v Ministry of Justice* [2013] EWCA Civ 961.
[26] *Ibid* [75].
[27] *Ibid* [61].

Lamb also sought to argue that in *Re A*,[28] the Court had sanctioned the taking of life, which could be applied by analogy to his case.[29] In that case doctors were permitted to operate to separate conjoined twins despite the fact that doing so would lead directly to the death of one of the twins. The Court of Appeal took into account comments in *Re A* emphasising the exceptional facts that led to the judgement, and agreed with them. It was accepted that the case represented 'too slender a thread' to support the development sought by Lamb (and on behalf of Nicklinson).

The arguments for developing the common law compatibly with Lamb's purported common law rights to dignity and autonomy did not, as indicated, refer to the *ECHR* rights, despite the fact that under the HRA 1998, s6(1),(3) they could be argued before a UK court as a public authority upholding the common law. The reason for this, as the Court of Appeal unanimously recognised,[30] was that if English law prohibiting assisted suicide amounted to a proportionate interference with Nicklinson/Lamb's ECHR rights (as was found in the Court of Appeal[31] and later confirmed in the Supreme Court,[32] see below 6.7) then it would clearly be the case that killing on request would be proportionate also, given that the latter situation justifies/requires more extensive safeguards to protect life.[33] In other words the Court of Appeal considered that proportionality would be more clearly established in relation to killing on request.[34] This analysis is straightforwardly supportable under the PGC, since, as established in the previous chapter, general legal restrictions upon exercise of the generic right to enabled suicide by killing on request are justifiable under the PGC, due to the lack of *personal* signalling of suicide in such cases (see 5.4.2). However, as is argued below, the absolute prohibition on assisted suicide in English law is *not* a proportionate restriction on the generic right to enabled suicide. It is arguable that in the controlled circumstances in which it

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[28] *Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147.
[29] *R (Nicklinson) v Ministry of Justice* [2013] EWCA Civ 961 [62].
[30] *Ibid*.
[31] *Ibid.*
[32] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200.
[33] Lamb sought to argue that the Suicide Act should be interpreted compatibly with his rights if possible, since Parliament had not specifically addressed his issue (referring to *R v Secretary of State for the Home Department ex p. Simms* [2002] 2 AC 115,131; see at *R (Nicklinson) v Ministry of Justice* [2013] EWCA Civ 961 [65]). However, the Court of Appeal refused to accept Lamb's argument that a common law defence of necessity could be readily extended to the statutory offence of assisted suicide ([64]). The reason for this finding was firstly that there was no established fundamental right to suicide and secondly that the limitation of the purported common law right to commit suicide was not incidental or a result of general language ([66]).
[34] *R (Nicklinson) v Ministry of Justice* [2013] EWCA Civ 961 [64].

is anticipated that killing on request could occur, in which the signalling of consent to killing would be clear, that the prohibition does not serve the aim of protecting the vulnerable.

Lord Neuberger in the Supreme Court, referring to assisted suicide, sought to defend a hard distinction in English law between killing on request and assisted suicide using a 'suicide machine' (a device which even a paralysed claimant such as Nicklinson could control in order to commit suicide).[35] Lord Neuberger considered as follows:

> Indeed, if one is searching for a satisfactory boundary between euthanasia or mercy killing and assisted suicide… I believe that there may be considerable force in the contention that the answer, both in law and in morality, can best be found by reference to personal autonomy.[36]

This *obiter* finding is generally correct in terms of judicial reasoning as to proportionality under the PGC, since it is clearly more justifiable to restrict claims to enabled suicide that require another to control the suicidal 'device' (see 5.4.2). However, the common law doctrines relied on by Nicklinson and Lamb clearly do not provide for the suicidal potentially incompetent agent (PIA) to signal to an official empowered to interfere that he desires to commit suicide.

In conclusion, it is clear that judicial reasoning as regards the development of the common law offence of murder does not recognise the hypothetical suicidal claimant's (S's) generic right to enabled suicide as regards the "take my life" claim. The failure to develop the common law to permit Nicklinson/Lamb's claims may be contrasted with the permission for other life-shortening behaviour that occurs as part of a course of medical treatment, referred to above (6.2)[37] and in subsequent chapters. The failure to resolve this inconsistency *within* the common law in *Nicklinson* is clearly an opportunity missed but, while the capacity of the common law to be developed inventively to protect fundamental rights is lauded by the

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[35] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [95] per Lord Neuberger. In the High Court Nicklinson had originally sought to claim that an assistor should be permitted to enable his suicide via a device operable from his eye-blink computer *R (Nicklinson) v Ministry of Justice* [2012] EWHC 2381 [3].
[36] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [95].
[37] *R (Nicklinson) v Ministry of Justice* [2013] EWCA Civ 961 [26], [57], [61].

English judiciary as regards certain common law principles/rights, especially as regards free speech and freedom of information (*Simms*;[38] *Kennedy*[39]), the lack of a common law right to 'privacy' clearly undermines the willingness of English courts to do so in the context of a right to dignified suicide (eg *Wainwright*[40] – no such right). Thus, relying on common law principle to limit the common law offence of murder was viewed as too radical a development by the Court of Appeal. That argument was not raised in the Supreme Court. The claim was arguably more suited to being advanced as an application of the Article 8 right to dignified suicide under the HRA;[41] the Court of Appeal considered the Article 8 claim but found that the interference represented by the prohibition on assisted suicide was justified under Article 8(2).[42] In the Supreme Court the claim relating to the common law was not pursued. The decision in the Supreme Court is discussed below as regards the proportionality of English law on assisted suicide affecting the "help me die" claim (see 6.6, 6.7). However, before considering the Supreme Court's approach to *substantive* proportionality in *Nicklinson* the chapter will firstly address the 'procedural' approach to the Article 8 right to dignified suicide in *Purdy* (discussed also in 3.6.3) which informed the Supreme Court's findings.

6.4 English law prohibiting assisted suicide and the "help me die" claim

It is worth restating the "help me die" claim (set out in 1.3.3), where S is the suicidal claimant, O is an official empowered to interfere, E is the person enabling the suicide:

> S wishes to die but is unable to do so in the way he chooses. He claims that O should not interfere when E provides the requisite assistance with his suicide.

The following discussion seeks firstly to develop an account of the procedural account of the government's responsibility to secure the Article 8 right to dignified suicide in English law referred to in chapter 3 (see 3.6.3). This initial statement of the law will omit the involved legal reasoning as regards the characterisation of the Article 8 right (the various plausible

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[38] *R v SSHD ex parte Simms* [1999] 3 WLR 328.
[39] *Kennedy v the Charity Commission* [2014] UKSC 20.
[40] *Wainwright v Home Office* [2003] UKHL 53.
[41] *R (Nicklinson) v Ministry of Justice* [2013] EWCA Civ 961 [48].
[42] *Ibid* [114].

interpretations of the Convention right to enabled suicide was discussed in chapter 3) and will also omit customary discussion of detailed legal requirements primarily pertaining to the "take my life," "end my suffering," "let me die" situations despite possible overlap between such requirements and those pertaining to assisted suicide. The reason for the omission of discussion of legal requirements pertaining to the other situations is because a developed account of the law governing those situations is more readily achievable by dealing with these separately later in the thesis.[43] The various strands of judicial reasoning in the *Pretty* and *Nicklinson* cases will then be analysed to determine whether they approach the issue of proportionality in relation to the Article 8 right to dignified suicide compatibly with the generic right to enabled suicide under the PGC. The section will come to a final conclusion as to the proportionality of current law, taking the Supreme Court findings into account, in terms of the generic right to enabled suicide.

Before addressing the responsibility of the English State, as recognised by the Supreme Court, to secure the Article 8 right to dignified suicide as relevant to "help me die" claims, it is useful to outline, in brief, the nature of the prohibition on 'assistance' in another's suicide under s2(1) the Suicide Act. Section 2(1) covers a broad range of actions that the enabler (E) makes to assist S's purpose, as long as that purpose fits the legal definition of committing *suicide* (chapters 7 and 8 delineate two instances in which the legal definition of suicide deviates from the concept used in this thesis). Of particular relevance is the fact that the scope of the offence encompasses direct involvement in the acquisition and delivery of lethal medication, as requested by S in the "help me die" situation;[44] the proscribing of *delivery* of medication to the suicidal individual has been found to extend to delivery of the suicidal individual to the lethal medication.[45] It should be noted that the offence may also be committed even where there is in fact no suicide, nor even an attempt to commit it (s2(1)(B)). Section 2(1) was amended in 2009 by the Coroners and Justice Act 2009; the Court of Appeal in *Nicklinson*[46] confirmed that the changed wording would not alter the substantive interpretation of the law prior to the passing of the Act (relevant to the scope of enabling in

[43] The analysis of the legal requirements in the thesis is structured as follows: "take my life" is 6.3 above; "end my suffering" is considered in chapter 7; "let me die" is considered in chapter 8.
[44] *Re Z (Local Authority)* [2004] EWHC 2817 (Fam) [14].
[45] A combination of arranging, informing, supporting, and physically assisting the suicidal agent so that another/organisation may procure the lethal medication, as in *Re Z*.
[46] *R (Nicklinson) v Ministry of Justice* [2013] EWCA Civ 961.

terms of this thesis).[47] The Suicide Act s2(1) has not been subject to *successful* legal challenge under the HRA mechanisms of the s3 interpretative obligation or declaration of incompatibility (s4) since the *Pretty v UK*[48] judgment; nor have parliamentary committee findings that the Statute should be modified to be brought into line with the ECHR been heeded so far (JCHR 2004, 3.10), although the Assisted Dying Bill 2014-15, if successfully passed, would bring about some measure of compliance (see 9.5).

The morally/legally controversial and unusual status of the offence of *encouraging or assisting* a course of conduct, committing suicide, that is not itself an offence, was recognised contemporaneously with the passing of the Suicide Act 1961.[49] The basis for retaining the offence of assisting and encouraging has been repeatedly found to be the protection of the 'vulnerable'.[50] However, the statute anticipates that even where prosecutors can be satisfied that the evidential ingredients of the offence are fulfilled (threshold, or evidential test) it may not serve the aim of protecting the vulnerable to prosecute in certain circumstances, and to this end it requires the consent of the DPP to prosecute, by s2(4).[51] English judges have noted of the offence of assisting/encouraging suicide that '[i]n terms of gravity it can vary from the borders of cold-blooded murder down to the shadowy area of mercy killing or common humanity'.[52] A category of potential defendants (clearly within the offence) who assist in the suicide of a dependent who is not clearly 'vulnerable' and with whom they are intimate are not convicted and are rarely investigated (see 6.5). The fact that the offence purports to proscribe a broader range of assisting/encouraging behaviour than legal officials should deem to be harmful and worthy of prosecution has been established in terms of sentencing for the offence, and was reaffirmed by their Lordships in the *Purdy* case (below).[53] It was the non-prosecution of a category of defendants who assist non-'vulnerable' dependent intimates which forms the context to the challenges to the Suicide Act s2(1) and s2(4) mounted in *Pretty*,[54] *Purdy*[55] and *Nicklinson*.[56]

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[47] *Ibid* [21] referring to para 327 of the Explanatory Notes.
[48] *Pretty v UK* (2002) 35 EHRR 1.
[49] Eg HL Deb 02 March 1961 vol 229 col 254 per Lord Silkin.
[50] *R (Pretty) v DPP* (2001) EWHC 788 [54]; *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [63]–[66].
[51] An interpretation confirmed by the House of Lords in Purdy *R (Purdy) v DPP* [2009] UKHL 45 (HL).
[52] *R v Hough* [1984] 6 Cr App R (S) 406.
[53] *Ibid* for example [54] per Lord Hope and [83] per Lord Brown. See also *R v Howe* [2014] Crim 114.
[54] *R (Pretty) v DPP* [2001] UKHL 61.
[55] *R (Purdy) v DPP* [2009] UKHL 45.

6.5 The government's procedural responsibility: clarity of prosecutorial policy; the role of the Director of Public Prosecutions

6.5.1 Introduction

Both s2(4) of the Suicide Act 1961 and the DPP as a public authority have been the subject of legal challenges in *Pretty*,[57] *Purdy*[58] and recently in *Nicklinson*.[59] These have had the common goal of seeking to use the HRA mechanisms[60] to gain some assurance of non-prosecution of assistors in the event that the applicants decide to commit suicide with the latter's aid. Only in *Purdy* did the applicant's argument meet with success. The basis of *Purdy's* successful claim and the resulting action by the DPP will therefore be discussed; this discussion will also briefly touch upon the related claim by Martin (joined with the Nicklinson litigation in the Court of Appeal). Martin's appeal succeeded on a similar basis to that of *Purdy* in the Court of Appeal, but the Supreme Court dismissed his action on cross-appeal by the DPP.

6.5.2 The claim in Purdy v DPP

Purdy's claim was discussed in 3.6.2 but it is useful to briefly recount its facts in order to evaluate the reasoning and outcome of the case in this section. Purdy sought guidance as to whether her husband would be prosecuted for helping her travel to Switzerland to receive an enabled suicide.[61] She challenged the DPP's failure to promulgate a policy specifically addressing assisted suicide and sought a mandatory order or other declaratory relief in order to require the DPP to do so under ss6, 7 HRA 1998.[62] Purdy's claim must be read in the context of s10(1) of the Prosecution of Offences Act 1985 which provides that the DPP shall

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[56] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200.
[57] *R (Pretty) v DPP* (2001) EWHC 788.
[58] *R (Purdy) v DPP* [2009] UKHL 45.
[59] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200.
[60] The DPP is a 'public body' subject to s1 HRA by virtue of s6 (*R (Pretty) v DPP* (2001) EWHC 788).
[61] *R(Purdy) v DPP* [2009] EWCA Civ 92 [3].
[62] *Ibid* [12].

issue a prosecutorial code setting out whether 'proceedings for an offence should be instituted'. On this basis Keir Starmer, the DPP at the time of the Purdy decision, had endorsed general guidelines (promulgated in 2004) that included public interest factors potentially applicable to Purdy's husband. These included (para 5.9) positive public interest factors particularly relevant to assisted suicide that appeared to indicate that Purdy's husband would be more likely than not to be prosecuted:[63]

> *e. the defendant was in a position of authority or trust*;
> *f. there is evidence that the offence was premeditated*
> *i. the victim of the offence was vulnerable*

The guidelines also set out various negative factors (para 5.10) that indicated that her husband was not likely to be prosecuted:

> *a. the court is likely to impose a nominal penalty*

The prosecutor would have been expected to take account of (a) in relation to the initial decision as to whether it would be worthwhile to prosecute. In addition to these the DPP had promulgated a detailed decision not to prosecute in the case of the parents of Daniel James who assisted their son to travel to Dignitas; the stated basis of that decision cast a degree of light on the way that these factors would be interpreted. Aspects of the James decision suggested that the strongly evidenced voluntary choice of the 'victim' was a near-decisive factor against prosecution,[64] but the decision did not, of course, amount to general guidelines. Despite some uncertainty in the lower courts,[65] the House of Lords briefly found that Article 8(1) was applicable to Purdy's claim to choose the manner and circumstances of her death on the basis of the ECtHR's finding in *Pretty v UK*[66] (as discussed in 3.6).[67]

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[63] *Ibid*.
[64] At para 35 of the decision: 'Neither [the parents] nor the family friend influenced Daniel James to commit suicide. On the contrary, his parents tried relentlessly to persuade him not to commit suicide. Daniel was a mature, intelligent and fiercely independent young man with full capacity to make decisions about his medical treatment. There is clear evidence that he had attempted to commit suicide on three occasions and that he would have made further attempts if and whenever an opportunity to do so arose. On the facts of this case, these are factors against prosecution.'
[65] *R (Purdy) v DPP* (2009) HRLR 7 (HC) [58].
[66] (2002) 35 EHRR 1.

Purdy did not challenge the proportionality of the 2004 guidelines, but rather argued that they failed to meet the standard set by the ECHR jurisprudence in terms of the Article 8(2) 'in accordance with the law' test.[68] In *Purdy's* case the generally applicable terms of the 2004 code and existence of dedicated prosecutorial teams set up to deal with sensitive and ethically controversial prosecutions such as in respect of assisted suicide for the terminally ill were found to be insufficient to meet the foreseeability and accessibility requirements of the test and were therefore found not to be in 'accordance with the law' in terms of Article 8(2).[69] Lord Hope, with whom their Lordships unanimously agreed, issued the following mandatory order:

> Director to promulgate an offence-specific policy identifying the facts and circumstances which he will take into account in deciding, in a case such as that which Ms Purdy's case exemplifies, whether or not to consent to a prosecution under section 2(1) of the 1961 Act.[70]

6.5.3 The 2010 Guidelines after Purdy

The DPP fulfilled this order in February 2010 by issuing the Policy for Prosecutors in in Respect of Cases of Encouraging or Assisting Suicide (2010) (2010 Guidelines)). The guidelines confirmed that, where the ingredients of the s2(1) offence are proved, prosecutorial discretion will be exercised so that where the suicidal 'victim' exhibits self-reflective, reasoning signalling behaviour this will be taken as a reason against prosecution. This was made clear by the following factor in favour of non-prosecution: 'the victim had reached a voluntary, clear, settled and informed decision to commit suicide'.[71] Many of the

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[67] *R (Purdy) v DPP* [2009] UKHL 45 (HL) [34-39].
[68] *Ibid* [40]. The Convention principle of legality requires the court to address itself to three distinct questions. The first is whether there is a legal basis in domestic law for the restriction. The second is whether the law or rule in question is sufficiently accessible to the individual who is affected by the restriction, and sufficiently precise to enable him to understand its scope and foresee the consequences of his actions so that he can regulate his conduct without breaking the law. The third is whether, assuming that these two requirements are satisfied, it is nevertheless open to the criticism that it is being applied in a way that is arbitrary because, for example, it has been resorted to in bad faith or in a way that is not proportionate.
[69] [54].
[70] [55].
[71] 2010 Guidelines, para 45.

other factors listed by the DPP can be read in the light of the latter factor, including the following factors militating in favour of prosecution listed in paragraph 43 of the 2010 guidance:

- (2) The victim did not have the capacity (as defined by the Mental Capacity Act (MCA) 2005) to reach an informed decision to commit suicide (see further 8.4);
- (4) The victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect;
- (7) The suspect pressured the victim to commit suicide;
- (9) The suspect had a history of violence or abuse against the victim

The guidelines also contain requirements that are indirectly relevant to the 'voluntary, clear, settled and informed decision to die': one of the factors listed in favour of prosecution was that the person seeking suicide was under 18. The age of the 'victim' is straightforwardly relevant to the degree of understanding he possesses in general. One factor which is listed as in favour of prosecution is that there is evidence that the suicide created a financial benefit to the suspect; it is also designed to address the suspicion of pressure or bullying of the person who was being assisted (Para 43, negative factor 7).

Other factors, however, are more doubtfully connected to the goal of establishing that the suicidal choice of the 'victim' was voluntary. The fact that the suspect 'was wholly motivated by compassion'[72] is equivocal as regards assessing the victim's voluntary choice. The requirement of compassion can be interpreted as being indirectly relevant to voluntary choice in both a procedural and a substantive sense. The factor of compassion impliedly presupposes that the enabler is an *intimate* rather than a professional (O'Sullivan 2014). This interpretation is explicitly supported by the following factor in favour of prosecution: 'the suspect was acting in his… capacity as a medical doctor, nurse, other healthcare professional,

[72] *Ibid* para 43, factor 6.

a professional carer [whether for payment or not] (this factor was later amended following applicant Martin's claim in the *Nicklinson* litigation, discussed below). [73]

This factor was also presumably included as a means of seeking to ensure that the choice of suicide was voluntary: the term 'compassion' reinforces the notion that the suspect's behaviour must not indicate that pressuring or persuading has occurred (Mullock 2010, 454). This latter sense of 'compassion' implies that the prosecuting team should evaluate the suspect's behaviour as conforming to their perception of *sensitivity*. However, the 'wholly motivated by compassion' factor could also indicate that prosecutors should require that the primary motivation of the suspect was a response to the suspect's distressing circumstances, rather than being a response to the suspect's suicidal desire; this latter interpretation of compassionate behaviour indicates that the prosecuting team should identify whether the suspect's behaviour conforms to their perception of 'mercy'. What is meant by mercy in this instance is an ultimate recognition that the suicidal person need not fight against his desperate circumstances any longer; this is the definition that is associated with 'mercy killing' (eg Law Commission 2006).

The 'mercy' approach to compassionate non-prosecution is supported by the following factor: that 'the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide'. The reason why dissuasion is more closely associated with mercy than with sensitivity is that a compassionate response would be to oppose the desire to commit *suicide* rather than accede to the 'victim's request (Mullock 2010, 456). To illustrate this point further, this factor (at that time not represented in official guidance) was significant to the decision not to prosecute the parents of Daniel James; the parents had not relented in their efforts to dissuade their son from his suicidal purpose; they had engaged in their son's suicide purely as a response to his anguish at losing his mobility (DPP 2008). Only where the 'dissuasion factor' implies a struggle to *understand* and ultimately accede to the request for assisted suicide can it be understood to support voluntary choice.

[73] *Ibid* para 43 factor 14.

The division between voluntary choice and mercy as interpretations of the factors in paragraph 43 and 45 are significant for suicidal claimant S's generic right to enabled suicide in the "help me die" situation, since only where he is suffering at the time when he has taken the decision can he be the subject of mercy. If this interpretation were adopted by the DPP then the prosecutorial factor would apparently not operate to diminish the risk of interference by a relevant official. The potential for these factors to undermine protection for enablers who participate in clearly voluntary suicide formed the background to applicant Martin's complaint in Nicklinson, just as the capacity for the generic prosecutorial factors to do the same for Purdy's husband had formed the background to her successful complaint.

6.5.4 The claim in Nicklinson *by applicant Martin*

The factor in favour of prosecution of suspects who deal with the victim in a professional capacity (DPP 2010, para 43, factor 14) was the subject of a further challenge by Martin, which was conjoined with the *Nicklinson* decision at the Court of Appeal and Supreme Court stages. The basis for Martin's argument in the Court of Appeal, the DPP's successful counterclaim, and the Supreme Court's suggestions about clarity will be considered in brief as they illustrate the nature and limitations of ECHR rights-based litigation based on s2(4). The Court of Appeal found that the lack of more detailed guidelines as regards the way in which relevant prosecutorial factors would affect professional/organised enablers (particularly doctors) meant that his request for assistance from such enablers could not be sufficiently informed.[74]

The background to Martin's appeal concerned general uncertainty about the status of dependents and suicide. Martin, who suffered from locked-in syndrome (almost total paralysis), was dependent on his wife and a team of professional carers; however, unlike Purdy, his partner was opposed to arranging or assisting in his suicide in any way. He sought to commit suicide 'legally' relying on the permissibility of suicide by refusing food (discussed as regards the "let me die" situation in chapter 8), but this attempt failed. Martin therefore sought to travel to Dignitas as Purdy desired to do; however, being paralysed

[74] [140].

(unlike Purdy when she planned her suicide) and lacking a partner who supported his purpose, Martin was required to achieve this purpose with professional assistance. The basic steps towards suicide required contacting/joining Dignitas, obtaining medical records and reports from doctors to be sent to Dignitas, making travel arrangements and sending Dignitas money.[75]

In Martin's conjoined appeal as to the DPP's policy he argued that while the guidelines had clarified the DPP's exercise of his discretion for an individual such as Purdy, relying on the assistance of intimates, they had not clarified the DPP's discretion as it applied to someone in his situation, who did not have that option.[76] He claimed that treating professional assistance as a factor in favour of prosecution interfered unjustifiably with his Article 8 right to dignified suicide. He argued that the exercise of the DPP's discretion did not satisfy the qualitative elements of the 'in accordance with the law' test under Article 8(2) for people in his position. Martin's challenge echoed Purdy's in that he sought a mandatory order that the DPP's current guidelines on professional assistance were insufficiently clear in his case to provide meaningful guidance. The Court of Appeal agreed with this reasoning on the basis that healthcare professionals were not in a position to foresee whether or not they would be prosecuted for coming to the assistance of individuals such as Martin.[77] The Court of Appeal was prepared to grant a mandatory requirement to the DPP to clarify this aspect of the policy, interpreting such an order as in the spirit of the *Purdy* judgment. However, the DPP (now Alison Saunders) revealed during argument before the Supreme Court that she had interpreted the guidelines in a manner that would give Martin the requisite certainty and was advised, though not required, to revise the guidelines to meet his claim.[78] She said that she had interpreted the guidance to apply to a specific category of professional defendants, which were those *in a caring relationship* with the victim (DPP 2010, para 43.14). The Supreme Court therefore accepted the DPP's submission that issuing a mandatory order would be

[75] Factor 14 was potentially applicable to a particularly broad range of acts assisting his suicide (*R (on the application of AM) v DPP* [2012] EWHC 470 [31]).
[76] *R (Nicklinson) v Ministry of Justice* [2013] EWCA Civ 961 [43].
[77] *Ibid* [144].
[78] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [143].

unnecessary and that English Courts should interfere with the constitutionally protected discretion of public prosecutors only where necessary as within the principle in *Purdy*.[79]

The departure from the strict wording of the Suicide Act 1961 s2(1) represented by the public interest factors for prosecution has created a degree of constitutional difficulty in that it is not for prosecutors, nor for courts, under the unwritten UK 'constitutional settlement,' to relieve those within the UK's jurisdiction from legal penalty for engaging in legally prohibited conduct (Keown 2009). The claim by Martin, and the subsequent revision of the policy, illustrates the encroachment upon prosecutorial policy that has resulted from the breadth of the offence of assisted suicide. It is argued that a notional distinction is drawn by the Supreme Court between permissible protection of the Article 8 right to dignified suicide through *guidance* by the DPP, who is instructed on matters of clarity by the courts, and an impermissible *prosecutorial legalism* whereby the courts direct the DPP to refrain from prosecution by enacting binding 'guidance'. Lord Neuberger summed up the reasoning of their Lordships as follows:[80]

> …we are here concerned with a very unusual crime which is the subject of a specific policy. However, that does not undermine the force of the constitutional argument that it is one thing for the court to decide that the DPP must publish a policy, and quite another for the court to dictate what should be in that policy. The purpose of the DPP publishing a code or policy is not to enable those who wish to commit a crime to know in advance whether they will get away with it. It is to ensure that, as far as is possible in practice and appropriate in principle, the DPP's policy is publicly available so that everyone knows what it is, and can see whether it is being applied consistently.

The Supreme Court therefore confirmed the importance of the division between giving effect to the Article 8 right to dignified suicide by – in effect – a disapplication of the Suicide Act s2(1) to certain categories of defendant, and giving effect to such a right by ensuring that a

[79] *R (Purdy) v DPP* [2009] UKHL.
[80] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [141].

potential 'victim' (S) can engage a potential 'suspect' (E) who can then make an informed decisions about the consequences of involving himself in the exercise of S's right.[81]

The creation of guidelines applicable to cases of clearly voluntary and informed suicide and compassionate assistance reflects the entrenched nature of compassionate non-prosecution and non-conviction of those who assist the suicide of non-vulnerable, dependant intimates. However, the guidelines' status as merely a codification of the current DPP's policy on this matter is, it is argued, a failure to rule *by* law even if the Article 8 right to dignified suicide has been indirectly vindicated by the 2010 Guidelines. If, hypothetically, a socially conservative DPP were to alter the guidance to decisively reject voluntariness as a crucial factor against prosecution and instead favour evidence of compassion that was closer to a theorised sanctity of life position[82] this would be within the scope of *Purdy* and *Nicklinson* (see further 2.4 and 8.2), despite favouring prosecution of those who would enable those in their positions. Adopting a more legalistic approach to protection of the Article 8 right to dignified suicide would encroach on the discretion of public prosecutors, which is provided for by the guidelines themselves,[83] and in the *Nicklinson* judgment.[84]

6.5.5 Conclusion and application of the PGC

In terms of hypothetical suicidal claimant S's generic right to enabled suicide in the "help me die" situation, the English legal requirement in s2(1) will straightforwardly infringe his right if it requires an official (O) (empowered to interfere) to interfere with the person enabling S (E) where such interference is not necessary to minimise the risk of incompetent suicide (see 4.5.2). The application of the PGC in this thesis assumes that the generic right to enabled suicide is secured by *legally enforceable rights* which cannot include 'soft law' (a description which arguably characterises the guidance), and therefore, as the DPP's discretion to prosecute has been preserved, the guidelines do not answer to the demands of the PGC (4.5). English law, as argued in the previous chapter, is potentially justifiable as creating a *near-*

[81] *R (Purdy) v DPP* [2009] UKHL 45.
[82] I.e a position which supported interference in suicide in the public interest except in narrow instances where 'natural life' had come to an end (see further 7.2).
[83] The guidelines contain an explicit requirement that public prosecutors must be free to weigh the *factors as they choose*, thus maintaining their discretion (DPP 2010, paras 39-40).
[84] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [141].

absolute prohibition which over-expansively protects 'the vulnerable', but which lacks the administrative capacity/resources to reduce its expansiveness. But the fact that the DPP's policy results in *de facto* non-prosecution of a category of defendants who act to enable the clearly voluntary suicide of competent individuals who are intimate with and dependent on the defendant is not relevant to such a legal evaluation.

It is, however, significant as an indication of support for rights-based legal reform that legal institutions have endorsed a situation whereby the category of defendants who are *de facto* excluded from prosecution are those defendants who are intimates of the suicidal potentially incompetent agent (PIA), and are most likely to have achieved 'proximity'[85] with the latter's purpose (see 5.2.3). The guidelines allow for prosecution of such defendants where the enabler's capacity to evaluate the suicidal PIA's competence has not been sufficiently established, reflecting, to an extent, a commitment to safeguards on competent suicide that are justifiable. However, the guidance departs from such a commitment where it sets out factors that address acts of 'merciful' assistance. Furthermore, the guidelines are obviously not directed towards the suicidal 'claimant' victim, but to the enabler 'suspect', and therefore administrative resources cannot appropriately be engaged to establish the competence of PIAs until *after* the suicidal act has been taken, which is an aspect of the English legal position that was criticised in the *Nicklinson* litigation.[86] The argument that the vagaries of the guidance should be resolved by the interpretation and creation of laws in accordance with the generic right to enabled suicide is considered below and in the subsequent chapters.

6.6 Background to the proportionality analysis under Article 8(2): Pretty and Nicklinson

As discussed in chapter 3, Diane Pretty – who suffered from motor neurone disease – sought an assurance from the DPP that he would not prosecute her husband for assisting her suicide, which was refused on the basis that he had no power to give such an undertaking. Pretty

[85] By proximity is meant a close relationship in which the competence of the suicidal PIA to pursue his purpose is able to be understood, see 5.2.3.
[86] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [173].

based her claim for judicial review of his refusal upon several of her Convention rights (discussed in 3.4.2-3.4.3) under the HRA 1998. She also argued that if the DPP was not required to issue an assurance then s2(1) Suicide Act 1961 should be declared incompatible with her Convention rights (under s4 HRA).[87] The Home Secretary intervened as an interested party to defend the compatibility of the scheme. Pretty's Convention rights, including Article 8(1), were not found to be engaged. It is useful to consider the reasons for this finding briefly since they illuminate the English judicial approach to the Convention right to dignified suicide and to the sanctity of life principle prior to *Purdy*. However, it must be emphasised that the contrary finding by the House of Lords in *Purdy,*[88] based on Pretty's application to the ECtHR in *Pretty v UK,*[89] confirmed that Article 8(1) *is* engaged (overturning the House of Lord's finding in *Pretty*).

Lord Bingham, giving the lead judgment in *Pretty v DPP*, did not accept that Pretty's Article 8(1) right was protected. He agreed with the Secretary of State's argument that:

> …the right to private life relates to the manner in which a person conducts his life, not the manner he departs from it, although it includes the right to refuse treatment… [a]ny attempt to establish a right to die founders on the same objection as the attempt based on article 2: that the alleged right would extinguish the benefit on which it was supposedly based. [90]

Lord Hope confirmed that 'private life' in Article 8(1) should be understood to refer to the way in which a person lives, rather than the way in which he dies, and therefore, while the way in which the 'closing moments' of life are experienced is within the Article 8 right to private life, he did not accept that Article 8(1) could encompass an obligation to give effect to her wish to undergo assisted suicide.[91] Their Lordships confirmed the status of the sanctity of life principle in English law and its incompatibility with recognition of a right to assisted suicide under Article 8(1). It was argued that the principle was firmly established, since the

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[87] *R (Pretty) v DPP* [2001] UKHL 61 [1-2].
[88] *R (Purdy) v DPP* [2009] UKHL 45.
[89] *Pretty v UK* (2002) 35 EHRR 1.
[90] *R (Pretty) v DPP* [2001] UKHL 61 [23].
[91] *R (Pretty) v DPP* [2001] UKHL 61 [100].

only 'exceptions' to this principle arose due to the doctrine of double effect and refusal of withdrawal of treatment, as discussed above (see 6.2).[92] Lord Hobhouse in particular stridently defended the sanctity of life principle as embedded in English criminal law and as opposing assisted suicide.[93] The findings of the House of Lords on Article 8(2) were therefore intended merely to offer completeness in response to Pretty's arguments, rather than addressing the demands of necessity and proportionality in depth.

The Secretary of State's argument as regards Article 8(2) was that the infringement of Pretty's potential Article 8 right must be balanced against the protection of the 'rights of others'[94] and that the possible risk to the 'vulnerable' was sufficient to restrict Pretty's Article 8(1) right.[95] The House of Lords confirmed the findings of the trial judge, Tuckey LJ, as regards Article 8(2). Tuckey LJ viewed the relevant legal materials as inconclusive, referring to the Canadian Supreme Court case of *Rodriguez*[96] in which Lamer CJ suggested a number of criteria to distinguish between different suicidal persons[97] but which were not accepted by the other Justices due to the risk of abuses (a point also made by Lord Sumption in *Nicklinson*).[98] The Court further did not find conclusive support in laws addressing assisted suicide in other nations. Lord Mance in *Nicklinson*, referring to the modern Supreme Court of British Columbia in *Carter*[99] later echoed Tuckey LJ's finding as regards a judicial procedure, as discussed below (see 6.7).[100] Tuckey LJ raised concerns about the defensibility of a criterion limiting applications for assisted suicide to individuals suffering from terminal illness, on the basis that so doing would create arbitrariness as to the justifying basis of self-determination, implying that a slippery slope towards a wider availability of assisted suicide,

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[92] *R (Pretty) v DPP* [2001] UKHL 61 [55] per Lord Steyn.
[93] *R (Pretty) v DPP* [2001] UKHL 61 [111].
[94] *R (Pretty) v DPP* [2001] UKHL 61.
[95] *R (Pretty) v DPP* [2001] UKHL 61 (HL) [55-62].
[96] *Rodriguez v British Columbia (Attorney General)* [1993] 3 SCR 519.
[97] *Ibid*, 579; the criteria are as follows: (1) an application to a superior court; (2) evidence from a treating physician and independent psychiatrist that the applicant was competent and had made the decision freely and voluntarily, and one of the physicians must be present when the applicant committed suicide; (3) the physicians must also certify that she is and will become physically unable to commit suicide without help and that she knows and understands her continuing right to change her mind; (4) notice and access must be given to the regional coroner; (5) the applicant must be examined daily by one of the certifying physicians; (6) the permission would expire within 30 days; and (7) the act causing death must be that of the applicant herself and no-one else.
[98] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [220].
[99] *Carter v Canada (Attorney General)* [2012] BCSC 886.
[100] Joint Committee on Human Rights in its Seventh Report of Session 2002–2003 (HL Paper 74, HC 547) and Twelfth Report of Session 2003–2004 (HL Paper 93, HC 603).

or even euthanasia, would be a possibility.[101] As indicated, these issues were re-raised in the *Nicklinson* case more than a decade later; however, in that case it was undisputed that the claims engaged the Article 8(1) right of the suicidal claimants, since the validity of such a right had been confirmed in *Purdy*.[102]

In the *Nicklinson* case the Supreme Court faced claims from two applicants as to the compatibility of the Suicide Act s2(1) scheme described above with the applicants' Article 8 right to dignified suicide as it applied in their situations. Those applicants were Mrs Nicklinson and Paul Lamb. Mrs Nicklinson was putting the argument on behalf of her deceased husband Tony Nicklinson.[103] The situation of the late Tony Nicklinson was essentially the same as that of Paul Lamb, described in full above (see 6.3). When *Nicklinson* was litigated before the Divisional Court, Macur J found that a proportionality analysis could not be conducted by the Court since the issues of evidence and principle raised were a matter for Parliament and, furthermore, that he was bound by the prior House of Lords decision in *Pretty* as regards proportionality (despite the fact that Nicklinson's Article 8(1) right was found to be engaged).[104] These findings, and the death of Tony Nicklinson to which they related, undermined the proportionality analysis that was ultimately addressed by the Supreme Court. Nevertheless, the findings in *Nicklinson* as regards proportionality are extremely significant for future claims, since a significant degree of judicial support was found for a declaration of incompatibility between the Article 8 rights of such claimants and s2(1) of the Suicide Act 1961.

6.7 The margin of appreciation and proportionality in *Nicklinson*

6.7.1 Introduction

[101] *R (Pretty) v DPP* (2001) EWHC 788 (HC) [60].
[102] *R (Purdy) v DPP* [2009] UKHL 45.
[103] Having taken over his claims as administratrix of his estate; also by virtue of the judgement in *Ulrich Koch v Germany* (2012) (App no 497/09) judgment of 19th July 2012 (see 3.4.3).
[104] *R (Nicklinson) v Ministry of Justice* [2012] EWHC 2381 [38].

The majority in the Supreme Court did not attempt to conduct a straightforward proportionality analysis under the Article 8 right to dignified suicide; only Lady Hale and Lord Kerr were prepared to do so, and on that basis they found that a declaration of incompatibility should be issued – a hugely significant, but minority, finding. The Lords who thought it was not appropriate to make a finding about proportionality in general in the *Nicklinson* case differed as to their basis for doing so. Lord Sumption, with whom Lords Hughes, Reed and Clarke agreed, may be interpreted, to borrow Lord Neuberger's phraseology,[105] as finding that the Court was not *constitutionally* competent to make a finding that the Suicide Act 1961 s2(1) was incompatible with Article 8 due to the moral and political sensitivity of the issue, thus agreeing with Macur J. Lord Neuberger, with whom Lords Mance and Wilson agreed, considered that the UK courts were constitutionally competent to decide the issue, but doubted whether the courts were *institutionally* competent to arrive at such a conclusion as regards Paul Lamb and Mrs Nicklinson in the instant case. They argued that the political sensitivity and complexities of assisted suicide required a cautious response from UK courts, but that the courts were empowered to judge such a case. Thus there were three strands of argument as to the judges' competence to *conduct the proportionality analysis*

6.7.2 'Constitutionally incompetent' to conduct the proportionality analysis

Lord Sumption's finding that the UK courts were not constitutionally competent to resolve the issue of proportionality was founded on the broad 'margin of appreciation' doctrine, referred to in 3.6, which was accorded to signatory states by the ECtHR in *Pretty v UK*. It was accepted by all their Lordships that the ECtHR in *Pretty* had accorded a broad margin of appreciation to the UK which encompassed the s2(1),(4) scheme.[106] Lord Sumption referred to one conception of the 'substantive' margin of appreciation referred to in 3.6.2, which finds that in the case of a 'legitimate diversity of cultural values' signatory States may arrive at

[105] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [67].
[106] Eg *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [119].

radically different approaches to the ECHR rights.[107] He argued that in terms of the questions of principle raised by claims concerning the proportionality of the s2(1) scheme:

> The real question… is how much risk to the vulnerable we are prepared to accept in this area in order to facilitate suicide by the invulnerable. This is a particularly difficult balance to draw in a case where the competing interests are both protected by the Convention. For this reason, there is an important element of social policy and moral value-judgment involved. The relative importance of the right to commit suicide and the right of the vulnerable to be protected from overt or covert pressure to kill themselves is inevitably sensitive to a state's most fundamental collective moral and social values.[108]

Lord Sumption argued that the clash between two 'fundamental and inconsistent' moral values required a Parliamentary, rather than judicial, response, because the electorate should be able to choose between them.[109] He argued that Parliament currently held to the judgement in the Suicide Act 1961 since it had not so far enacted legislation departing from the s2(1),(4) scheme and the judges should not subvert the democratic process.[110] Finally Lord Sumption argued that the courts lacked the institutional competence to survey 'controversial and complex questions of fact arising out of moral and social dilemmas' especially as regards the future implications of issuing a declaration.[111] The latter concern evokes the classic evidential 'slippery slope' objection to rights-based legal reform concerning the elusive nature of the risk created and the difficulty of overseeing apparent safeguards to reduce the risk (eg Keown 2012, 157-59). Lord Sumption concluded that even were the s2(1),(4) scheme deemed to create a blanket ban on assisted suicide it would be rationally defensible. On that basis he concluded that only where Parliament had 'abdicated the task of addressing the question at

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[107] *Ibid* [229].
[108] *Ibid*.
[109] *Ibid* [230].
[110] Lord Bingham observed in *R (Countryside Alliance) v Attorney General* [2008] AC 719 [45] 'The democratic process is liable to be subverted if, on a question of moral and political judgment, opponents of the Act achieve through the courts what they could not achieve in Parliament.'
[111] *Ibid* [232].

all' would the courts be entitled to declare that s2(1) created a disproportionate interference with the Article 8(1) right.[112]

6.7.3 'Institutionally incompetent' to conduct a proportionality analysis in the instant case

Lord Neuberger agreed with Lord Sumption as regards the margin of appreciation whereby the balance to be struck between competing interests fell to be determined by the UK state institutions.[113] However, Lord Neuberger disagreed with Lord Sumption that moral equivocation at Strasbourg, as regards such fundamental ECHR interests, should be understood as preventing domestic judges from arriving at a conclusion about proportionality.[114] Lord Neuberger, referring to the judgement of *Re G*,[115] recognised the importance of *institutional* separation of powers based on decision-making competence.[116] He recognised that the UK courts should be cautious when embarking on such an analysis:

> …where the provision enacted by Parliament is both rational and within the margin of appreciation accorded by the Strasbourg court, a court in the United Kingdom would normally be very cautious before deciding that it infringes a Convention right. As Lord Mance said in *In re G*, the extent to which a United Kingdom court should be prepared to entertain holding that such legislation is incompatible must depend on all the circumstances, including the nature of the subject-matter, and the extent to which the legislature or judiciary could claim particular expertise or competence.[117]

Having determined that the question was appropriately considered in terms of decision-making competence, Lord Neuberger set out the elements of the proportionality test, referring to Lord Reed's judgment in *Bank Mellat*:[118]

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[112] *Ibid* [233].
[113] *Ibid* [74].
[114] *Ibid*.
[115] *Re G (Adoption: Unmarried Couple)* [2009] AC 173 per Lord Hoffmann [36], Lady Hale [116-20], Lord Mance [130].
[116] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [75].
[117] *Ibid*.
[118] *Bank Mellat v HM Treasury* (No 2) [2013] 3 WLR 179.

> (a) is the legislative objective sufficiently important to justify limiting a fundamental right?; (b) are the measures which have been designed to meet it rationally connected to it?; (c) are they no more than are necessary to accomplish it?; and (d) do they strike a fair balance between the rights of the individual and the interests of the community?[119]

Lord Neuberger, with whom Lord Wilson agreed,[120] judged criterion (a) and (b) to be fulfilled by the s2(1) scheme: s2(1) was designed to protect the lives of the vulnerable and the weak following the ECtHR in *Pretty.*[121] Lord Neuberger considered the prohibition of assistance in s2(1) to be an 'indirect and blunt instrument in that it is, as a matter of practice, aimed at those who need assistance in committing suicide rather than those who are weak and vulnerable'.[122] However, referring to the statement of Lady Hale in *Purdy* that 'people who are vulnerable to all sorts of pressures, both subtle and not so subtle, to consider their own lives a worthless burden to others',[123] he concluded that a 'blanket ban on assisting suicide will protect the weak and vulnerable, and, more particularly, that it may well be that those who are in the same unhappy position as [the] Applicants, but do not wish to die, are in a particularly vulnerable position'.

Lord Neuberger found that the question of institutional competence therefore was pertinent to criterion (c) and (d). He identified, in addition to the direct concern with the weak and vulnerable, an indirect concern that any modification of s2(1) would send a message to the weak and vulnerable that, essentially, suicide 'was an option'.[124] He denied that these direct and indirect concerns could be considered to be merely speculative, despite the lack of evidence of abuses in available legal materials.[125] However, significantly, he accepted that it might be possible to construct a legal procedure which did rule out risk to the vulnerable:

> …if a proposal were put forward whereby Applicants could be helped to kill

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[119] *Ibid* [70*ff*.] per Lord Reed.
[120] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [197].
[121] *Ibid* [65].
[122] *Ibid* [85].
[123] [2010] 1 AC 345.
[124] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [86].
[125] *Ibid* [88].

> themselves, without appreciably endangering the lives of the weak and vulnerable, then this objection could be overcome, or at least circumnavigated.[126]

Lord Neuberger's conclusion on this point was in part driven by the development of the law in cases of refusal of vital treatment, which is considered further in 8.3.

Lord Neuberger briefly considered the s2(1) scheme's moral foundation. He accepted, of course, the moral basis of protecting the weak and vulnerable, but the relevance of this judgment depended on the evidential concerns which he had raised separately. He accepted that the decriminalisation of suicide undermined the duty-based conception of the sanctity of life:

> …if the primacy of human life does not prevent a person committing suicide, it is difficult to see why it should prevent that person seeking assistance in committing suicide. [127]

Lord Neuberger accepted, however, that the s2(1) scheme might have a moral basis in terms of an emphasis on the value of human life in the form of Parliament conveying a message to society that all lives are valuable; however, he did show scepticism about what he termed 'semaphore' legal judgments.[128] He recognised that such an argument was better made in terms of evidence, as a matter of indirect protection of the 'weak and vulnerable'.[129] Lord Neuberger recognised that English law had drawn a consistent moral judgment against 'killing on request' which should be respected, and could be applied to arguments in favour of voluntary euthanasia. However, he recognised that the applicants could commit suicide in a way that respected this judgment by the use of a 'suicide machine' under the control of the suicidal person.[130] He disagreed with Lord Sumption[131] that such a development was contrary

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[126] *Ibid* [89].
[127] *Ibid* [90].
[128] *Ibid* [91].
[129] *Ibid* [90].
[130] *Ibid* [64].
[131] *Ibid* [93]. Referring to the case of *R v Kennedy (No 2)* [2008] AC 269 per [16] Lord Bingham.

to the moral distinction between killing on request and assisted suicide, implying that moral choices about fundamental interests were beyond the purview of judicial decision-making.[132]

Lord Neuberger drew together the above considerations about the protection of the vulnerable and morality to address whether it was appropriate for the UK courts or for parliament to determine the proportionality of s2(1) under Article 8(2). Lord Neuberger resisted a prescriptive approach to the boundary between instances in which the proportionality analysis could be left to Parliament and those where it could not.[133] He noted that a cautious approach should be adopted to a finding that s2(1) was disproportionate on an issue which would create a direct confrontation between the courts and the legislature,[134] but he also recognised that the courts had a duty to interfere.[135]

However, Lord Neuberger accepted the need for executive / parliamentary consideration of arguments/evidence.[136] He found that the unfocused nature of the appeal raised by Nicklinson and Lamb lent greater force to the Secretary of State's argument on this point,[137] although he accepted that the terms of s4(2) HRA 1998 created scope for Parliament to enact a scheme based on its review of the relevant factors that would be most capable of satisfying proportionality. Lord Neuberger criticised the current operation of the s2(4) scheme in terms of providing protection for the vulnerable, arguing that it was not entirely effective. But he found that its arguable inefficacy – which might have led to a clear finding of its disproportionality – did not appear with sufficient pertinence in relation to the substance of the complaint by the claimants in *Nicklinson*.[138]

Lord Neuberger concluded that the evidence and arguments presented before the Supreme Court could in principle form the basis of a finding that the s2(1),(4) scheme was disproportionate in Article 8 terms as regards the claims by Mrs Nicklinson and Mr Lamb. However, he found that Parliament should be granted an opportunity to address the

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[132] *Ibid* [98], [110].
[133] *Ibid* [101].
[134] *Ibid* [104].
[135] *Ibid.*
[136] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [107].
[137] *Ibid* [106].
[138] *Ibid* [108-109].

arguments presented in the case and develop its own proportionality analysis without pressing the issue by issuing a section 4 declaration. He approved of Lord Mance's analysis of the institutional limits of the UK courts' approach to proportionality on this point:[139]

> …some judgments on issues such as the comparative acceptability of differing disadvantages, risks and benefits have to be and are made by those other branches of the state in the performance of their everyday roles, and that courts cannot and should not act, and do not have the competence to act, as a primary decision-maker in every situation. Proportionality should in this respect be seen as a flexible doctrine.

Lord Mance, with whom Lord Neuberger agreed, approved Lord Reed's statement in *Bank Mellat*[140] on the general use of proportionality which, he argued, militated towards according a domestic 'margin of appreciation' in relation to the 'measure no more than necessary' test (c):

> …that the limitation of the protected right must be one that 'it was reasonable for the legislature to impose', and that the courts were 'not called upon to substitute judicial opinions for legislative ones as to the place at which to draw a precise line'. This approach is unavoidable, if there is to be any real prospect of a limitation on rights being justified… especially, one might add, if he is unaware of the relevant practicalities and indifferent to considerations of cost. To allow the legislature a margin of appreciation is also essential if a … devolved system such as that of the United Kingdom, is to work, since a strict application of a 'least restrictive means' test would allow only one legislative response to an objective that involved limiting a protected right.

Lord Mance considered that the particular claims raised in the *Nicklinson* case were not sufficiently supported by evidence to arrive at a judicial determination as to

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[139] *Ibid* [166].
[140] *Bank Mellat v HM Treasury (No 2)* [2013] 3 WLR 179 [71-76].

proportionality.[141] Lord Mance judged the secondary legal materials to be inherently deficient (a 'short cut'), and inconclusive as regards the risk to the vulnerable (a point upon which their Lordships were unanimous).[142]

6.7.4 Constitutionally and institutionally empowered to conduct the proportionality analysis

Lady Hale and Lord Kerr disagreed with the other Supreme Court Justices, on the institutional competence point, and with Lords Sumption and Lord Reed as regards constitutional competence. Lady Hale accepted that Parliament would be the only forum which was capable of bringing the law into general compliance with the ECHR rights. She considered that Parliament would be free to *respond* to a declaration of incompatibility.[143] Lord Kerr similarly denied that a 'domestic' margin of appreciation should be accorded any force, finding that Parliamentary debate and prosecutorial discretion should not carry the weight accorded to them by the other Lords.[144] Lady Hale found that the argument could be framed in terms of principle: was the judgement captured in s2(1) that the able-bodied could generally lawfully commit suicide without interference and the extremely physically incapable generally could not defensible?[145]

Lord Mance disagreed with Lady Hale's reasoning on this point. The disagreement focused on the meaning of the following passage from *Gross v Switzerland* (Second Section):[146]

> …an individual's right to decide by what means and at what point his or her life will end, provided he or she is capable of freely reaching a decision on this question *and acting in consequence*, is one of the aspects of the right to respect for private life within the meaning of article 8 of the Convention.[147] (my emphasis)

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[141] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [175].
[142] *Ibid* [178],[182].
[143] *Ibid* [300].
[144] *Ibid* [327].
[145] *Ibid* [308-309].
[146] *Gross v Switzerland* (App no 67810/10) judgment of 14th May 2013. The later, Grand Chamber, judgement overruled this decision *Gross v Switzerland* (App no 67810/10) judgment of 29th September 2014.
[147] *Gross v Switzerland* (App no 67810/10) judgment of 14th May 2013 para 59.

Lord Mance adopted an interest-based view of the Convention right, arguing that the law does not recognise a right to commit suicide since there is no claim 'to suicide' that could found a duty to assist (see further 2.2.4). His Lordship referred to Lord Bingham's findings in *Pretty* which were based on the problematic status of suicide as a benefit.[148] There was no 'right' to suicide on this view, but rather a permission,[149] and on this basis Lord Bingham found in *Pretty* that there was no inconsistency in permitting suicide by s1 of the Suicide Act 1961 and restricting assisted suicide by s2(1).[150] Lady Hale and Lord Kerr disagreed on the basis that the right to suicide was not demonstrated by a claim to suicide, but by control over the benefit of life, preferring the *Pretty* formulation of the Article 8 right to dignified suicide: a person's right to respect for her autonomous choices about how and when she wishes to die.[151]

Lord Kerr and Lady Hale both attacked ss 1 and 2(1) of the Suicide Act as creating an anomaly in permitting suicide and penalising assisted suicide; they also emphasised that enabling control over life was capable of exercise in other areas of English law (see further 8.3). Lady Hale identified the proportionality analysis as relying on the creation of a balance between the Article 8 right of the claimant and the Article 2 rights of others (discussed in 3.4); her analysis would be compatible with an interpretation of the legal requirement upon an official empowered to interfere (O) to exercise that power to interfere with the hypothetical suicidal claimant's (S's) generic right to enabled suicide (see 4.4). Lady Hale argued that while a general ban on assisted suicide was in principle proportionate to the aim of protecting the rights of others, due to the risk of abuse, the Secretary of State had not provided either reason or evidence to the effect that the claimants could not be distinguished from this general vulnerable group. Lord Kerr, with whom Lady Hale agreed,[152] emphasised that:

> Nothing in the case advanced by the Secretary of State establishes that the claimants' inclusion in the group affected was unavoidable to protect the

[148] *R (Pretty) v DPP* [2001] UKHL 61 (HL).
[149] *Ibid* [18], [26].
[150] *Ibid* [35].
[151] *Ibid* [307] per Lady Hale; [334] per Lord Kerr.
[152] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [315].

> vulnerable group. In the absence of evidence—or at least a tenable basis on which it might be asserted—that this was required, it is impossible to conclude that the interference with the claimants' rights is proportionate.[153]

Lady Hale suggested that the High Court would be sufficiently able to distinguish people with a settled and considered desire to die, such as the claimants, from vulnerable people who did not have such a considered wish.[154] She and Lord Kerr argued that the High Court could, in exceptional circumstances, be used to establish decision-making capacity, freedom from undue influence, the informed basis of the decision and physical capacity. Lady Hale argued that such a procedure would provide sufficient flexibility to meet proportionality requirements without challenging the general ban on assisted suicide.[155] She conceded that such a procedure was not raised in evidence or argument before the Supreme Court,[156] but argued that the Supreme Court was in principle required to decide the issue as part of its commitment, as an organ of the British State, to make an honest attempt to safeguard the claimants' Article 8 rights.

Lord Mance considered that a blanket ban including Nicklinson/Lamb was questionable in terms of proportionality because it was not clear that vulnerable people could not be excluded from such a narrow category of ostensibly rational persons who had a settled and considered desire to end their lives.[157] However, Lord Mance cited the lack of conclusive agreement about the criteria upon which the court would decide who was vulnerable and not, especially in the case of a criterion of 'unbearable suffering'.[158] He cited the criterion of *terminal illness*, which was not relevant to Nicklinson/Lamb, which he considered had greater support as a criterion for limiting the scope for abuse than did a test that did not.[159] Lord Mance found that the lack of a conclusive exclusion of any risk in a court review procedure was problematic, even though the risk appeared to be low in his judgment. He considered that it was sufficient to create a basis for deferring to the legislature's assessment that an absolute

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[153] *Ibid* [352].
[154] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [314] per Lady Hale; [355] per Lord Kerr.
[155] *Ibid* [316].
[156] *Ibid* [318].
[157] *Ibid* [186].
[158] *Ibid* [187].
[159] *Ibid* [188].

prohibition was necessary to protect the vulnerable. He concluded, on this basis, that there were insufficient grounds to overturn or revisit the evidential assessment in *Pretty* or to remit the issue to the High Court; the latter judgment was also influenced by previous and current legislative consideration given to assisted dying.[160]

Thus, Lady Hale and Lord Kerr agreed that a declaration of incompatibility (s4 HRA) between s2(1) and Article 8 must be made, and proceeded to do so. Lords Wilson and Neuberger considered that a declaration did not need to be issued in relation to the instant case, concerning Nicklinson and Lamb, but stated that in future they would be prepared to issue one if Parliament did not act to make some provision for enabled suicide. Lord Mance found that it would be justifiable to issue such a declaration in future but considered that it would be more appropriate to do so in the case of a terminally ill applicant. The influence of these judgments on the current Parliamentary response is discussed fully in chapter 9.

6.7.5 Conclusions and application of the PGC to the approach to the margin of appreciation and proportionality in Nicklinson

The politically motivated 'constitutional' limitation on court involvement in assisted suicide as a sensitive and controversial issue of human rights, which was argued for by Lords Sumption, Clarke, Reed and Hughes was narrowly defeated in the *Nicklinson* case.[161] The narrow majority of the 9 member Supreme Court was prepared to accept that a declaration of incompatibility under section 4 HRA could be issued in cases concerning the Article 8 right to dignified suicide. This finding is of vital importance for the protection of controversial rights to self-determination in general, and particularly of the generic right to enabled suicide, since it represents a commitment by the UK courts to vindicate such rights in law if Parliament in effect forces such an action by inaction (as discussed in chapter 9, various attempts at legislation post-*Pretty* have failed to address the problem of assisted suicide). The decision is one of enormous significance in terms of the approach of this thesis to judicial reasoning since as a result judicial acceptance of an Article 8 right to 'dignified suicide' is extended fully into English law, going beyond the procedural approach in *Purdy,* and the

[160] *Ibid* [190].
[161] *Ibid* [229].

analysis in *Pretty,* to include a substantive proportionality analysis (see further 3.6.3). The deferential approach to proportionality in *Pretty* in the House of Lords, based on the finding, influenced by the sanctity of life principle, that Article 8 did not protect the right to dignified suicide, has now been decisively abandoned in English law.

As discussed in the previous chapter, a near-absolute prohibition can be defended on the basis that safeguards against deficient signalling and depressed or pressured suicide are justifiable under the minimal responsibility to secure the generic right to enabled suicide (see 5.3-5.6) but, in light of *Pretty*, the failure to provide even an exceptional judicial procedure is not. The majority in *Nicklinson* agreed that the adoption of a general law could only occur in the context of a legislative scheme designed to protect the rights of the vulnerable, but the judges who found the courts to be 'constitutionally competent' to decide in this context divided over the use of a judicial process to give effect to the individual's Article 8 right to dignified suicide in general, bearing in mind the institutional limits within which judicial decision-making necessarily occurs in the UK.

The division between the approaches to a judicial procedure to give effect to the Article 8 right to dignified suicide arguably resulted from differing possible approaches to the conception of the nature and interest of such a right in *Pretty,* as was discussed in chapters 3 and 4. The conception of the Convention right to enabled suicide under the PGC is based on the will-conception, as was established in chapter 4, implying control over the benefit of the generic right to 'life' (see 4.4; see also 2.6 and 3.5). Lady Hale and Lord Kerr arguably supported this conception since in their judgment the relevant judicial process would be one capable of determining whether in the particular circumstances affecting specific PIAs the right to enabled suicide could be exercised. In other words, the process would evaluate the ability of individuals to control their fundamental interests (see further 2.2.4 and 3.5).

Lord Mance's opposed stance however, was not based on the will-conception of the Article 8 right. The ECtHR in *Pretty v UK* left scope for an alternative domestic interest-based interpretation of the Article 8 right to dignified suicide; it is argued that such a conception informs the proportionality analysis under the 'institutionally incompetent' position in *Nicklinson*, especially that of Lord Mance, with whom Lord Wilson agreed. Despite accepting that the Supreme Court was 'institutionally incompetent' in the instant case, Lord

Neuberger agreed with elements of the analysis of both Hale and Mance. Lord Mance's position was advanced on the basis of fundamental doubts as to the suitability of a judicial process to determine the competence of a claimant to undergo enabled suicide based on his Article 8 right to self-determination, despite his acceptance that a judicial process was constitutionally able to establish the boundaries of such a concept in relation to suicide. He did not accept that claimants were entitled to enabled suicide on the basis of competence alone, but rather on the basis of particular circumstances of *suffering* and that a court was not qualified to come to a judgment as to the quantification of such suffering.[162] This provided the basis for his argument that the *Pretty* analysis of proportionality in the House of Lords could still be upheld.[163] In contrast, Lady Hale and Lord Kerr broadly accepted that the court *must* be able to govern the exercise of the Article 8 right to dignified suicide of potentially incompetent claimants, since courts must be competent to consider questions of the exercise of fundamental rights and, indeed, they argued that this had already occurred in relation to suicidal refusals of treatment (see further chapter 8.2).[164] On this basis they rejected as inconsistent the absolute nature of the legal judgement represented by s2(1) of the Suicide Act, identifying it as fundamentally unresponsive to signalling as to the desire to commit suicide.

Lord Mance defended the deferential analysis in *Pretty v DPP*[165] in the following terms:

> Whatever else may be said about the evidential position, it is not in my opinion sustainable to suggest that there is no evidence and to describe as ruminations a conclusion that permitting assisted suicide in the case of persons in Mr Nicklinson's and Mr Lamb's position would pose a relevant risk to vulnerable people…[166]

Lord Mance argued that the issue raised was an evidential one concerning the way that claimants' interests were to be protected, and the level of risk that should be accepted, despite

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[162] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [187].
[163] *Ibid* [190].
[164] *Ibid* [319].
[165] *Ibid* [173].
[166] *Ibid* [183].

accepting that the Suicide Act 1961 itself, at least as it applied to the applicants, did not approach to even a minimal accommodation of their Article 8 right to dignified suicide. The court's role, he considered, was to balance rights and interests, and the balance between the claimants' rights and the relevant interests of vulnerable people could not be established with certainty by reference to either domestic or international law.[167] This understanding of the right to 'dignified suicide' evinced by Lord Mance does not rely on a judgement about the exercise of rights, but rather on a conception of self-determination that is detached from such an exercise, since on the latter analysis, as advanced by Lord Kerr, the quantification of risk to 'vulnerable' people is based on a level of risk affecting those who cannot exercise the relevant right because they are not competent to do so. The relevant risk on the will-based view under the PGC is therefore necessarily quantifiable in terms that are relative to the responsibility of a judge to determine questions of the exercise of human right to control fundamental wellbeing (see 5.2.3). Lord Mance's 'constitutional competence' position therefore merely implies that the High Court should not necessarily be bound in future by the analysis in *Pretty v DPP*; his finding was that a *new* proportionality analysis could find that the Suicide Act 1961 s2(1) was compatible with Article 8 *even* in the absence of an exceptional procedure. Under Lord Mance's position the High Court in future would be able to examine the possibility of introducing such a procedure in order to answer to the demands of proportionality under Article 8, but could find that those demands were answered to even where such a procedure was not available.

Lord Mance defended a Parliamentary solution as ideal since it would be able to conduct the evidential exercise necessary to frame effective safeguards.[168] In particular, legislation would give legitimacy to safeguards that limited the availability of a procedure to particular categories of suicidal applicant. Lord Mance suggested that terminal illness would be a limiting criterion that would be preferable to relying on 'extreme suffering', since so doing would enable English courts to avoid quantifying such suffering.[169] A similar concern is evident in recent amendments to the Assisted Dying Bill 2014-15, which provide for a judicial mechanism for deciding cases of assisted suicide *confined* to those who are

[167] *Ibid* [188].
[168] *Ibid.*
[169] *Ibid* [186-188].

terminally ill (see further 9.3 and 9.5.2). Such a legislative-judicial solution would also resolve the constitutional competence problem identified in Lord Sumption's judgment.[170] This approach would provide a degree of accommodation for the right to enabled suicide in English law, and is, of course, preferable to the current situation, but fails to achieve direct recognition of the generic right to enabled suicide. Persons in the situations of Nicklinson and Lamb would not be able to obtain an enabled suicide under the current terms of the Bill. Furthermore, the Bill is now unlikely to be debated in the commons before the general election in May, thus, it has missed its legislative window; on this basis Jane Nicklinson has recently lodged an application to the ECtHR (BBC 2014).

6.8 Conclusion

It was established in the previous chapter that the near-absolute restriction upon enabled suicide does not satisfy proportionality in terms of the PGC in the absence of even an exceptional procedure (see 5.4-5.6). The approaches of Lady Hale and Lord Kerr to the Article 8 right to dignified suicide create a basis for direct recognition of the generic right to enabled suicide in English law, but it appears unlikely that their approach will be adopted, at least initially, in terms of legal reform. It must furthermore be emphasised that substantive judicial recognition of the Article 8 right to dignified suicide is far from established, given the significant dissent in *Nicklinson*, and the somewhat equivocal support for a judicial procedure by even those justices who supported such a development. As commentators have observed, the future recognition of such a right, without legislative support, depends on the membership of the Supreme Court that would resolve a possible future claim (Finnis 2015, 4). The current lack of domestic protection for the generic right to enabled suicide *in law* is not ameliorated by the DPP's guidelines, since officials remain legally entitled to interfere with enabled suicide, including in cases of assistance in the suicide of competent dependent intimates. A future DPP would merely have to adjust the Guidelines to restrict categories of defendant whom it is not in the public interest to prosecute in accordance with a theorised sanctity of life position, but do so in a *clear* way; if that occurred the current level of (arguable) *de facto* recognition of a generic right to enabled suicide would be lost or diminished. The Supreme

[170] *Ibid* [233] per Lord Sumption,

Court confirmed that the DPP clearly had a constitutional entitlement to exercise this discretion, and, hypothetically, if she was to consult the courts as to future revisions (or if the guidelines were once more litigated), then such advice or mandatory order could refer only to questions of clarity and not of *substance*. It is therefore the case that there is currently, after *Nicklinson*, no formal basis upon which to question the DPP's judgement as to which categories of defendant to prosecute.

It is argued that if an approach contemplated by the majority in *Nicklinson* is adopted by the Assisted Dying Bill 2014-15, or by a future judicial procedure, this would represent an opportunity missed to adopt an ethically rational approach to the Article 8 right to dignified suicide. Excluded categories of claimant whose self-determination can be established as being of the same order of acceptability as that of claimants who are not excluded, could readily argue that they were being arbitrarily discriminated against by exclusion from such a procedure. No doubt such claims would be met with official reluctance on the basis of 'slippery slope' concerns, which are justifiable under the PGC to an extent, but hard cases of evident and enduring suffering such as that of Nathen Verhelst's (discussed in the previous chapter, 5.6.3) would test judicial adherence to the formal restraints of a legislative procedure. The potential for apparent 'slippage' in favour of a more individually oriented will-conception approach to securing the Article 8 right to dignified suicide is, it is argued, provided for by the HRA mechanisms themselves (especially ss3 and 4), if the will to use them is apparent. The courts who must oversee the new scheme would remain subject to the Article 8 right to dignified suicide (s6 HRA). If, in formal terms, the legislative framework used *clear* words to exclude a particular claimant's condition, for example on the basis that it was non-terminal, the judges obviously could not give effect to such a right (s3(2); s6(2) HRA), but could issue a declaration of incompatibility between certain limiting provisions of the new scheme and Article 8. Reinterpretation of the new scheme under s3 HRA, or the legislative response to such a declaration, would not of course, under the PGC, represent 'slippage' but would instead represent movement towards recognition of the generic right to enabled suicide (discussed fully in chapters 9 and 10).

However, as discussed above and in the previous chapter, the lack at present of even an exceptional procedure to accommodate claims to enabled suicide does not mean that the exercise of the generic right to enabled suicide is not provided for indirectly and even, to a

very limited extend, *directly*, by English law. The sanctity of life principle in English law recognises two 'exceptions' to the proscription of intentional enabling of suicidal purposes, discussed above (see 6.2). The next chapter examines the possibility of the exercise of the "end my suffering" claim under the legal permission for life-shortening treatment; it is argued that the limitations to this permission based on the medical context and the doctrine of double effect can to an extent be supported indirectly under the PGC. Chapter 8, meanwhile, analyses English law governing withdrawal and withholding of vital treatment. The basis and possible justifiability of the apparent inconsistency that has developed between the freedom to assist suicide by 'omission' and the near-absolute prohibition on incompetent suicide are explored in detail.

Chapter 7: English law affecting "end my suffering" claims

7.1 Introduction

The "end my suffering" claim, as set out in 1.3.3, sets out the following hypothetical claim (where S is the person claiming suicide, O is an official empowered to interfere, and E is the person enabling S's suicide):

> S is in severe pain which he considers that he should no longer have to tolerate. S claims that O should not interfere when E ends his pain even if doing so results in ending S's life, a consequence which S accepts.

The suicidal claimant could possibly be enabled to commit suicide legally if E's conduct fell within the 'principle of double effect' (PDE) applied to 'life-shortening' lethal treatment. Under the principle a doctor treating a patient can be involved in enabling a 'suicide' which does not fall within the offence of assisting suicide or murder, set out in the previous chapter, because the action is deemed to be 'lawful' by virtue of being for the purpose of relieving pain and suffering and only 'incidentally'[1] shortens life:

> It is not… unlawful for a doctor to prescribe medical treatment which will necessarily hasten death where the purpose is to relieve pain and suffering.[2]

Thus, in the particular, narrow instance of life-shortening treatment doctrine, a *legal basis* exists for the exercise of the generic right to enabled suicide. The limitation is clearly justifiable since, as was established in chapters 5 and 6, a near-absolute prohibition on assisted suicide in English law is justifiable (if a judicial procedure is made available to hear exceptional applications). However, if the legal judgement represented by life-shortening treatment excludes categories of "end my suffering" claimants, without justifying such an exclusion in terms of the need for safeguards to establish competent suicide, then such a

[1] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [255] per Lord Sumption.
[2] *R (Nicklinson) v Ministry of Justice* [2013] EWCA Civ 961 [26].

limitation fails to weigh the generic rights of claimants correctly, which is not rationally defensible under the PGC (see further, discussion of applications of the PGC in 4.5). In order to identify whether such exclusion is justifiable it is necessary to establish the scope of this legal 'exception' to the general prohibition on enabled suicide.

English law governing 'life-shortening treatment' is strongly influenced by the sanctity of life principle. Where a doctor's conduct amounts to life-shortening treatment the theorised sanctity of life view considered in this thesis (that of Keown) finds that it is justifiable as a humane response to the suffering of a patient to seek to end that suffering by the use of pain-relieving treatments at the end of life where there is no intent to kill the patient. This chapter considers the theorised sanctity of life-based position of Keown, discussed in chapter 6, in the first section (7.2). It will be argued that the PDE applied to life-shortening treatment can be developed to encompass enabled 'suicide' in the form of enabled *dying*, although a 'requested' death of any sort remains anathema on this view. The chapter will then consider the legal doctrine governing life-shortening treatment. It will be argued that the doctrine retains its historic roots in the sanctity of life position, but that the basis in *treatment*, and a recent emphasis on patient autonomy in medical law (eg Ashby and Stoffell 1995, 136; Billings 2011), have led to development of the doctrine of life-shortening treatment (7.3). It has, it will be argued, reached a position closer to a doctrine of enabled dying whereby the suicidal request for pain relieving treatment forms the basis for the justifiability of the doctor's conduct; in essence this is a very narrow form of enabled suicide. The doctrine will finally be analysed and evaluated in terms of the generic right to enabled suicide (7.4).

7.2 The principle of double effect and the sanctity of life

The sanctity of life principle absolutely prohibits conduct that intentionally ends life; however, the principle of double effect (PDE), usually first credited to Thomas Aquinas (Bennet 1981), finds that voluntary lethal conduct may be acceptable in certain exceptional circumstances on the basis that there is no intention to kill. Aquinas observed of certain forms of voluntary lethal conduct, such as killing in self-defence, that the principle of double effect could operate so that such acts done without the intention to kill were not deemed to amount to impermissible killing (Aquinas 1274, II-II Q64 A5). The sanctity of life theory considered

in this thesis advances the PDE to justify certain forms of 'life-shortening' lethal treatment on the basis that such conduct is not intentional killing.[3]

The PDE applies where there are two (or more) consequences of an action which are certain to follow (to adjust Aquinas' terminology of 'effects'), one of which is the death of a person, but where only the non-lethal result is intended (Finnis 2011, 220*ff*.). Thus, in the context of 'enabled dying', this principle of double effect refers, broadly, to a situation where the death of the person is a 'side-effect' (eg Quinn 1993). The basis for the finding that a side-effect is unintended is disputed. A straightforward interpretation would be that the doctor's 'good' motive to relieve a patient's suffering is crucial to the permissibility of the doctor's action (*cf* Gormally 1995, 134). However, Keown disagrees that motive is crucial to the PDE and instead seeks to defend the distinction between intentional killing and life-shortening treatment on the basis of intention and foresight. It is useful to expand upon this additional element of Keown's argument in order to understand the development of the theorised sanctity of life position towards acceptance of a form of enabled suicide.

Keown finds that a 'good' doctor does not necessarily intend to kill or enable suicide where she provides life-shortening treatment, or ends a burdensome life-preserving treatment, because, while she foresees the lethal consequence of such conduct she does not intend to kill (2012, 141). It is viewed as implausible to draw a distinction not based on motive between such a 'good' doctor and a 'bad' doctor who does the *same action* but who wills the death of her patient when doing so because she wishes to facilitate his suicide (eg Price 1998). Price argues that Keown's position, if it is not based on motive, must be understood to be based upon the *quality of life* of the patient (Price 1998, 627; Price 2007, 558). However, Keown rejects this analysis and argues that his position is consistent with the sanctity of life view that a suffering patient's life cannot justifiably be ended on the basis of that he has a low quality of life (Keown 2006).

Keown's response to Price's criticisms of the sanctity of life position as regards life-shortening treatment/withdrawal is that it is only where the value of life is upheld as an

[3] *Airedale NHS Trust v Bland* [1993] AC 789.

absolute good in all circumstances that it would be impermissible to refuse to accept the permissibility of such conduct (a view he terms 'vitalism', see Keown 2002, 41). He accepts that life need not be artificially preserved at infinite cost to the patient, and that modern medicine provides for treatment options that *would* prolong life, but are so burdensome in terms of pain that it is asking too much of the patient to require him to undergo such treatment (eg Keown 2002, 231*ff.*). It is on this basis that he accepts that if a patient wishes for a form of treatment that treats the pain – even if death will thereby be hastened – rather than treatment that prolongs life, this should be permissible (Keown 2002, 39). A doctor understands that her conduct will bring the patient's vital signs to an end and intends to do so, but she does not intend to *kill* him; under Keown's view his life was brought to an end by the condition from which he is dying and suffering, and she merely foresees that her action which ameliorates his suffering will also hasten his death.

Keown maintains that such a position is not equivalent to the quality of life view espoused by Price, whereas Price argues that Keown's stance becomes conflated with such a view (Price 2007, 556; *cf* Keown 2002, 44). Keown sets out his view of the distinction between the quantity, quality and sanctity views of the value of life in the following paragraph:

> The SoL [sanctity of life], rejecting vitalism, holds that human life is a basic good but that it is not the highest good and that there is therefore no duty to preserve it at all costs. Rejecting the QoL [quality of life] approach, the SoL holds that human life is of intrinsic and not merely of instrumental value as a vehicle for a so-called 'worthwhile' life. (Keown 2002, 39)

It is on this basis that a doctor is justified in altering the treatment goal generally from curative to palliative:

> …the distinction… is between… those who think that the lives of all patients are worthwhile but that not all life-saving treatments should be carried out because they offer little hope of benefit or impose excessive burdens and, on the other, *those who think that certain patients are better off dead*. (Keown 2002, 111) (emphasis in original)

It is only in the context of non-curative palliative treatment that life-shortening treatment can be justified under this approach (life-preserving treatments could be permissibly withheld or withdrawn on this view outside that context; see next chapter, 8.2).

Keown's identification of the value of life as distinct from the preservation of 'vital signs' departs from a straightforward conception of the ending of the life of a human moral subject, and requires elaboration. As discussed in chapter 2, the definition of the intrinsic good of human life under the sanctity of life theory relies on the unique human capacity for agency (eg Finnis 2011, 85*ff.*; see also 2.4). From this position it is defensible to treat the possession of 'vital signs' as only one element of a broad tableau of interests that human agents possess. Keown's conception of the value of human interests is premised on an interest-based view of natural law and is opposed to the protection of interests on the basis of individual freedom which is supported by the PGC (Keown 2002, 212*ff.*). However, individual expressions of autonomy by the patient remain of significant weight under the interest-based view, and, as human interests are increasingly degraded, due, for example, to the progression of a degenerative disease, then the basic good of preserving vital signs may increasingly have to be balanced against the deterioration in the capacity to experience other basic interests necessary for human agency (eg Keown 2002, 154). This means that a person, who is suffering unbearably in this way, and who has signalled his sincere desire to die, may be justifiably enabled to die by another without contradicting the sanctity of life stance because his life has not been devalued by doing so in this narrow circumstance (Keown 2012, 143*ff.*).

The application of PDE to life-shortening treatment is controversial, in terms of the sanctity of life theory, where a doctor is aware that she is administering such treatment to a suicidal patient who requests it, since that is tantamount to participating in a form of enabled suicide (Billings 2011, 440). Keown appears to accept that the patient's suffering, his terminal illness and the patient's desire to die, are relevant to the lack of intention to kill, and thus to the permissibility of life-shortening treatment (eg 2002, 20*ff.*). However, Keown does not accept that a patient's *suicidal* purpose is thereby facilitated, but rather that his death is facilitated in order to 'ease his passing' (2012, 140*ff.*). He views the patient's suicidal purpose as one of the patient's fundamental interests that must inform a doctor's decision, if that decision is to be arrived at in a 'good' way, but he does not deem that purpose to be decisive. If a doctor

were to be directed by the suicidal purpose of the patient then, on this view, the doctor's actions would oppose the sanctity of life position.

The theorised sanctity of life approach to life-shortening treatment permits 'enabled dying' by life-shortening treatment in circumstances that are not dissimilar from the safeguards that may justifiably be enacted to restrict *competent* suicide under the PGC, discussed in chapter 5. These include extreme suffering (as a dialectically necessarily understandable reason for suicide), incurable and terminal illness (to evidence exhaustion of the agent's capacity to recover from his state of suffering), and measures to verify that the agent has signalled his suicidal desire (see generally 5.4-5.6). The PGC does not distinguish moral responsibility for *killing* in the case of 'life-shortening' treatments, from other forms of voluntary lethal conduct (eg Gewirth 1978, 41), and therefore, since acting voluntarily to create a sufficiently foreseen effect is straightforwardly what is meant by an 'intended' action in Gewirthian theory (eg Gewirth 1978, 50-51), such conduct should be characterised as enabled *suicide*.

As discussed below, the law governing life-shortening treatment has developed towards an enabled *suicide* position to an extent, due to a recent emphasis on legal protection for patient autonomy. This interpretation of the legal developments is criticised as creating a 'distortion' of the sanctity of life position by theorists, such as Keown (2012, 240*ff*), but, obviously, from the perspective of the PGC such developments can be viewed as a step towards securing the generic right to enabled suicide.

7.3 The principle of double effect in English law on life-shortening treatment

7.3.1 Introduction

The scope of the PDE applied to life-shortening treatment as a legal doctrine is uncertain due to the undeveloped state of the law (discussed in 7.3.2), but encompasses both lack of an intention to kill (7.3.3) and administration of life-shortening 'treatment' (7.3.4). The theorised PDE position, as developed above, is reflected in English law on life-shortening treatment, but not on 'life-shortening' *withdrawal* of vital treatment (which is discussed in the next chapter). It is argued below that the theorised sanctity of life-based double effect distinction

is reflected in law as a matter of intention, but that the influence of patient autonomy has exerted a degree of indirect influence over the doctrine as regards the *treatment* aspect of the doctrine (7.3.5).

The relevance of life-shortening treatment under the PDE to the idea of a right to 'assisted death' was vividly illustrated by the case of Annie Lindsell, who suffered from motor neurone disease. Lindsell initiated proceedings before the High Court, with only weeks to live, in order to clarify that her doctor should be permitted to end her life by administering diamorphine in quantities that would inevitably shorten it in order to avoid the distress caused by pain and by her fear of suffocation (BBC 2000). She withdrew her case after the High Court confirmed that her doctor's action would be permissible. Annie Lindsell's settled determination to commit suicide on the basis of anticipated suffering meant that her claim represents an unusual application of the PDE doctrine, which, as is discussed below, generally operates discretely from a clearly signalled suicidal desire (see also Huxtable 2007, 103, 105).

7.3.2 Background to the legal doctrine

Before developing the analysis of English law, it is useful to consider briefly certain circumstantial difficulties in the English regulation of life-shortening treatment in order to understand why English law has developed as it has. The courts technically consider practices of 'lethal treatment' to be homicide, but the lack of prosecutions has meant that the law is undeveloped (eg Huxtable 2007, 94*ff*.). The prospect of bringing serious criminal charges against (often) apparently compassionate professionals, the requirement of relying on a criminal process, and the common law nature of the legal position on murder in England, are all cited as reasons for the slow pace of legal change and for the paucity of firm precedent addressing the distinction between life-shortening treatment and murder (eg Huxtable 2007, 86*ff*.). Less justifiably, the courts are also accused of bias towards the medical profession (eg Huxtable 2007, 86*ff*.; Price 2006, 620*ff*.). The result is that prosecutorial behaviour does not necessarily uphold even the uncertain limitations of the legal doctrine of life-shortening treatment set out below, and there is only a limited and emerging awareness that certain life-shortening behaviours of doctors exist as social phenomena relevant to enabled suicide.

The English legal position is characterised by a reluctance to engage with the phenomenon of life-shortening treatment, especially as regards suicidal patients, despite the fact that in the absence of legal assisted suicide there is a case for open acceptance of such treatment in narrow circumstances. The vagaries of the principle of double effect as a basis for doctors' actions in non-curative palliative care, and reliance on terms such as 'primary intention,' are deemed to create a risk to patients who are receiving such care (Commission on Assisted Dying 2011, 51, 287). Furthermore, the paucity of case-law leaves the precise ambit of the doctrine uncertain. Finally the factual basis of the judgement that the use of sedatives should hasten death is considered to be questionable (Sykes and Thorns 2003; Pattinson 2014, 535).

The problem of theoretical, legal and practical uncertainty is not limited to patients who seek to rely on the legal rule on life-shortening treatment to enable their suicide, such as Annie Lindsell. The doctrine also creates a danger to those whom it should protect, since its imprecision means that it is susceptible to abuse, as demonstrated by the Shipman case (Shipman Inquiry 2003). Harold Shipman was manifestly unable to provide any cloak for his actions, but it would not have been difficult to provide such a cloak, especially in relation to a willing, but vulnerable, patient. As discussed below, the institutional setting within which treatment of a terminal condition of extreme suffering by a doctor takes place, and the existence of a treatment relationship, are potentially relevant safeguards protecting suicidal potentially incompetent agents (PIAs). Beyond these requirements the doctrine operates in an unpredictable way, with potentially disastrous results.

7.3.3 Intending to shorten life

The legal basis for the PDE in England stems from Judge Devlin's direction to the jury in *R v Adams*:[4]

> If the first purpose of medicine, the restoration of health, can no longer be achieved there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he

[4] *R v Adams* [1957] Crim LR 773.

takes may incidentally shorten human life.[5]

Judge Devlin, the presiding judge in *R v Adams*,[6] was a Catholic and an advocate of a sanctity of life-based double-effect principle as set out by St Augustine and Aquinas, which is the basis of the theorised approach considered above (7.2; see also Finnis 1995, 24-25).

The principle of double effect as applied to life-shortening treatment requires a narrower conception of the intention to kill than the one accepted as governing intention in general in English law (eg Patiinson 2014, 14-007). The generally accepted authoritative statement of intention, as is well established, was that made in *R v Woollin*.[7] In that case the House of Lords held that subjective foresight of a virtually certain consequence of an action is a form of intention.[8] The incompatibility of the conception of intent in *Woollin* with the PDE basis for life-shortening treatment is widely accepted (eg Keown 2002, 27-29).

Keown has argued that the decision in *Woollin*[9] placed one category of potential defendants, doctors, in an invidious position (2002, 27-29). Keown regards *Woollin* as wrongly decided, since it ignores the PDE in *R v Adams*[10] which had been confirmed shortly before that case by the House of Lords in *Bland*[11] (Keown 2002, 29). If a doctor understands that various actions taken as part of non-curative palliative care are virtually certain to accelerate death, then under *Woollin* the doctor would intend that death should result (Keown 2002, 27-29), as has been officially recognised (eg by Ward LJ in *Re A*),[12] but not resolved. Reconciliation between the two legal rules could be effected on the basis of the vagaries of jury trial. The direction by the judge in a case of intent as regards foresight of virtual certainty is that they *may* find intention, but they are not required to do so, and obviously the failure of a jury to

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[5] *Ibid.*
[6] *Ibid.*
[7] *R v Woollin* [1998] UKHL 28.
[8] *Ibid* at 98-97*;* see also *R v Nedrick* [1986] 1 WLR 1025 at 1028 per Lord Lane CJ 'Where the charge is murder and in the rare cases where the simple direction is not enough, the jury should be directed that they are not entitled to find the necessary intention, unless they feel sure that death or serious bodily harm was a virtual certainty (barring some unforeseen intervention) as a result of the defendant's actions and that the defendant appreciated that such was the case.' The decision is one for the jury to be reached upon a consideration of all the evidence.
[9] [9] *R v Woollin* [1998] UKHL 28.
[10] *R v Adams* [1957] Crim L R 773.
[11] *Airedale NHS Trust v Bland* [1993] AC 789.
[12] *Re A* [2001] 1 FLR 1 [56].

infer *Woollin* intention cannot be the basis for setting aside a jury verdict (Norrie 1999; Pattinson 2014, 499; Stark 2013, 156-57). It is deemed unlikely that the PDE will be overturned as a rule of English law, but this possibility cannot be ruled out (Huxtable 2007, 87*ff*.).

7.3.4 Pain-relief and life-shortening treatment performed by a doctor

The most straightforward aspect of the PDE doctrine applied to life-shortening treatment requires that there must be a course of treatment provided by a doctor. If a 'patient' was killed by a doctor in other circumstances then the legal rule does not apply. This was the position in the infamous case of Harold Shipman who killed a large number of his patients by administering sedatives in a sufficient dosage to suppress respiration where there was, as regards a number of victims, no evidence that this was part of normal medical practice directed towards relieving pain or otherwise.[13]

Life-shortening treatment is, by definition, medical care addressed towards *relief of pain* required due to a recognised medical condition of the patient.[14] The necessity that the doctor should prescribe a course of *treatment* is demonstrated by *R v Cox*,[15] which is the only case since *Adams* in which an English doctor has been charged successfully with attempted murder after a request for pain-relieving but lethal treatment by a patient. In this highly unusual case Dr Nigel Cox recorded in hospital logs that he administered an injection of potassium chloride to a 'patient',[16] in a form that had no recognised therapeutic purpose (as opposed to a barbiturate which could plausibly be associated with pain relief). Dr Cox clearly desired to relieve the extreme suffering of the patient who was in great pain and clearly and distinctly requested to be relieved of this suffering in numerous conversations with Dr Cox.[17] However, the lack of a therapeutic purpose as within normal palliative treatment evident from the administration of the pain-relieving treatment was found by the judge to prevent the

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[13] See eg Shipman Inquiry Trial Transcript 1999, Day 39.
[14] *Airedale NHS Trust v Bland* [1993] AC 789 at 865.
[15] *R v Cox* (1992) unreported 18th September 1991, referred to in *Airedale NHS Trust v Bland* [1993] AC 789 at 865, 892.
[16] *Ibid.*
[17] *Ibid.*

issuing of a direction based on the PDE doctrine (which was issued in *Adams*);[18] therefore Dr Cox's actions were described in the jury direction as intentional killing. The jury had little choice but to convict the doctor of attempted murder, which they did, reluctantly (Biggs 1996, 881).[19]

The conception of 'treatment' in *Cox* provides the basis for the conception of 'treatment' by the GMC. This is evident from various malpractice cases, such as that of Dr Munro. In Munro's case the drug pancuronium, which also had no recognised therapeutic value in the circumstances, although it was, crucially, considered to be capable of relieving pain, was administered at 23 times the normal dose to one dying infant, at the request of the parents, leading directly to respiratory failure (Goodman 2010, 567-8). Dr Munro admitted in the hearing that he had used the drug previously on another terminally ill baby. The drug was administered to two infants at Aberdeen Maternity Hospital (Goodman 2010). Dr Munro was cleared of malpractice.

7.3.5 Consent to life-shortening treatment and suicide

For action to amount to 'treatment' it is implied that the doctor and patient act within a normal treatment relationship. This implies that the patient has consented to that course of treatment. In 2013 the General Medical Council issued brief guidance to doctors concerning informed consent and 'end of life decisions,' which reaffirmed the responsibility of doctors to respect and support decisions of patients, including their informed consent to life-shortening treatment (GMC 2013, paras 1-4). The statement referred, for the first time, to the relevance of such treatment to assisting suicide, although it was merely stated, opaquely, that assisted suicide remains unlawful (2013, para 5). It is clear that the new 'patient autonomy' paradigm which is broadly recognised as a dominant force in modern medical law (Billings 2011) means that life-shortening treatments are controlled by the patient (if he is competent) and he can choose such treatments if he is offered them as part of palliative care. This is the case even if he desires to die. The facilitation of such a desire is contrary to the theorised sanctity of life-based PDE applied to life-shortening treatment considered above (Keown 2012,

[18] *R v Adams* [1957] Crim L R 773.
[19] *R v Cox* (1992) unreported 18th September 1991; *Airedale NHS Trust v Bland* [1993] AC 789 at 865.

140*ff*.).

Enabled suicide by life-shortening treatment under the PDE is therefore not legally restricted on the basis of the risk of incompetent suicide. However, official evaluation of competence is indirectly relevant, since consent is regulated by law and by institutional guidance which covers: official review of the signalling of consent to such treatment; 'capacity' under the Mental Capacity Act 2005 (MCA), and voluntariness and disclosure requirements (see 8.4-8.6) as well as advance decisions (see 8.7). Therefore English law provides for limited indirect official oversight of those patients, like Annie Lindsell, who might use the opportunity provided by the PDE applied to lethal treatment to commit suicide.

Neither a court nor a professional tribunal since *R v Adams*[20] has considered the consequence for a medical enabler if a clearly suicidal PIA received life-shortening 'lethal' treatment. It is possible, but extremely unlikely, that in a case where a suicidal patient was in severe pain and his consent to the treatment was evidently defective due to lack of capacity or to coercion, the doctor providing the life-shortening treatment could be charged with assisted suicide or murder or attempted murder. However, only where the doctor records that her actions were intended to assist the patient to commit suicide is she likely to be prosecuted and, obviously, she is unlikely to do so. The institutional stance of the medical profession is therefore one of official disengagement with suicidal patients and of *de facto* tolerance of enabling actions (Huxtable 2007, 111-112). The absence of direct oversight means that effective evaluation of the reliability of consent to life-shortening treatment by suicidal potentially incompetent agents is impaired (Jackson 2012, 15-16, 60).[21]

7.4 The principle of double effect, life-shortening lethal treatment, and the PGC

It is clear that the legal framework for life-shortening treatment is based on the sanctity of life position, which rejects rights-based moral approaches to assisted suicide in principle. However, the 'exception' for life-shortening treatment engages, indirectly, with safeguards for competent suicide under the PGC discussed in chapter 5. In particular, that exception

[20] *R v Adams* [1957] Crim L R 773.
[21] *Airedale NHS Trust v Bland* [1993] AC 789 at 838.

requires that the patient (S) is dying, is suffering extremely, and has requested such treatment from his doctor – who is in effect enabling his suicide (E). Therefore English law as to the PDE can be evaluated in terms of the generic right to enabled suicide, despite the explicit differences between the sanctity of life basis of English law on life-shortening treatment and the PGC. Evaluation in such terms is supported by the influence of patient autonomy on life-shortening treatment, which means that the suicidal choices of dying patients, such as Annie Lindsell, must be accommodated by doctors (as long as the doctor does not have the primary intention of assisting suicide). It will therefore be argued that it is unjustifiable for English law to refuse to recognise certain "end my suffering" claims where the claimant's suicidal purpose has been clearly signalled to his doctor, since they are within the scope of the 'extreme suffering' and 'dying' aspects of English law on the PDE and life-shortening treatment.

The limitation to extreme suffering (i.e. patients in severe pain), is defensible under the PGC on the basis that S's extreme suffering provides a 'good reason' for his suicide by lethal treatment (the term 'lethal treatment' is used to describe the doctor's enabling conduct for the sake of accuracy, since the PGC recognises that life-shortening treatments are intentional lethal conduct). By 'good reason' is meant that S's purpose is dialectically necessarily understandable to officials empowered to interfere who can therefore evaluate the doctor's participation in the patient's suicidal purpose (see further as regards 'extreme suffering' the dialectically necessary framework for judgements about suicidal purposes set out in 5.2.3). A suicidal PIA's basic generic interests are clearly undermined by experiencing extreme suffering, and the incurability of his condition and the fact that he is dying contribute to medical determinations as to whether the condition is sufficient evidence of 'extreme suffering'. In particular, as was argued in chapter 5 (see 5.4.6), such terminal and incurable conditions reduce the scope for doubts that the suicidal PIA might have the ability/opportunity to overcome his condition.

The legal restriction placed on the use of lethal treatment where the doctor's demonstrable desire is *not* to facilitate S's suicidal desire appears to be a straightforwardly irrational requirement in terms of the PGC. However, it is possible to interpret this requirement as compatible with the PGC to a limited extent as a safeguard against *pressured suicide* (see further 5.5). The PDE applied to life-shortening treatment requires that a doctor must remain

neutral as to a patient's suicidal decision, which could be justified as a measure to minimise the potential for doctors to influence the suicidal decisions of PIAs. The nature of a doctor-patient relationship is one in which the doctor typically has the capacity to exert influence over even a robust patient (see as regards undue influence in the medical context generally eg Pattinson 2002b), and thus an official could justifiably be empowered to interfere where a doctor's motive was non-neutral in terms of pressuring or encouraging suicide.

It is also justifiable under the PGC to distinguish the medical setting of a treatment relationship from other settings/relationships, such as a private/family setting, in which an "end my suffering" claim could be made. The opportunities provided by the English medical context and treatment relationship include record-keeping, professional guidance governing decision-making about non-curative palliative care, and professional oversight (Magnusson 2004). These factors all allow for the creation and review of an accurate record of the patient's signalled decision to end his life which are justifiable/required as a minimal procedural safeguard for suicidal signalling under the dialectically necessary framework (see further as regards signalling, 5.4). Therefore the restricted application of the PDE specifically to the context of life-shortening treatment, criticised as a distortion by sanctity of life theorists (eg Keown 2002, 27-29), is sustainable under the PGC.

However, the requirement that lethal treatment takes the form of 'pain-relief' in order to demonstrate that neither the patient nor the doctor intends suicide is unjustifiable as arbitrary under the PGC, unlike the above safeguards. The requirement of 'pain relieving' lethal treatment is irrational in practice since modern pain-relieving non-curative treatment applied 'normally' (i.e. not as a lethal treatment) is not understood to 'shorten life' (eg Sykes and Thorns 2003). Furthermore, the implication of such a requirement, that there is no intention to facilitate suicide, is directly contrary to the PGC. This requirement *diminishes* the patient's control over his suicide without any rational connection to a diminution of the chance that he is incompetent.

English law on life-shortening treatment also fails to engage with the need to minimise the risk of *depressed* suicide (i.e. 'self-oblivious' suicide where the suicidal PIA seeks suicide without regard to his generic interests, see for a full discussion, 5.2.5 and 5.6). There is a basic 'capacity' assessment for treatments in general under the Mental Capacity Act 2005

(discussed further in the next chapter), but in the context of the PDE the 'lethal' aspect of the treatment and the suicidal nature of the patient's purpose need not (arguably *must* not) be directly considered by the patient, which is clearly contrary to competent rational suicide. It is submitted that in this respect a doctrine to accommodate 'lethal treatment' under the PGC would represent a superior safeguard for the generic right to life of patients than is represented by current law on life-shortening treatment. A patient such as Annie Lindsell, who was within the narrow limits of English law on lethal treatment, interpreted in accordance with the generic right to enabled suicide, could achieve her purpose with *support* from her doctor.

7.5 Conclusion on the "end my suffering" claim

The principle of double effect as regards *life-shortening treatment* is indefensible under the PGC, but the limitation to conduct amounting to *lethal treatment* for a suicidal patient who requests it when he is suffering and dying is defensible. The PDE basis of the doctrine would therefore be rejected under the PGC in favour of a straightforward motive/intention divide whereby a doctor who intended lethal treatment (within the safeguards) would be within the law, as long as she did not clearly encourage/pressure the patient. The benefits of rationalising the law in this area extend beyond "end my suffering" claimants, since the life-shortening treatment doctrine can readily be abused (see also as regards the dangers to patients of legal confusion, the Commission for Assisted Dying 2011, 52).

It should be emphasised that the underlying ethic of compassionate restraint in the medical profession represented by the life-shortening treatment doctrine is of benefit to dying patients who are *not* suicidal and do not wish to confront death explicitly. A doctrine of compassionate restraint provides necessary relief for doctors where a patient is reluctant to make a decision as to the manner and timing of his death. This latter phenomenon has been described as the 'right *not* to know' (it is reflected in official guidance: eg GMC 2008, para 14). Gewirthian reform would seek to establish a separate doctrine of lethal treatment that formed part of the regulation of physician-assisted suicide. It will be argued in chapters 9 and 10 that such a development would enhance legal certainty since there would then be a clear distinction between rational suicide and compassionate life-shortening treatment.

The next chapter will address another form of legally recognised life-shortening treatment decision, which is the refusal/withdrawal of life-preserving treatment and clinically assisted vital care (eg withdrawal of a ventilator). The permissibility of refusal/withdrawal of vital treatment is defended by Keown as part of a theorised sanctity of life position on the basis of the PDE but, as discussed below, English law has clearly departed from the narrow safeguards such a position would impose (above, 7.2 and below 8.2). In particular, there is no requirement that a patient is suffering or dying, as there is under the PDE-based life-shortening treatment doctrine (see 8.2.3). The recognition in law of suicidal refusals of treatment, discussed in chapter 8, is similar to the recognition for suicidal lethal treatment under the PGC above; however, the lack of safeguards governing such refusals means that the scope to exercise the right to enabled suicide is far greater in relation to withdrawals than it is for lethal treatment. It is proposed in chapter 10 that the unjustifiable inconsistency of these positions could be remedied by creating a narrow right to 'physician enabled suicide' encompassing lethal treatment and suicidal withdrawal of treatment (see 10.3.1).

Chapter 8: English law affecting "let me die" claims

8.1 Introduction

The "let me die" claim is set out as follows (where S is the person claiming suicide, O is an official empowered to interfere, E is the person enabling S's suicide):

> S requires vital healthcare if he is to survive but he does not wish to receive it (or continue to receive it) because he desires to die. He claims that O should not interfere when E does not provide (or discontinues the provision of) vital healthcare to him.

This claim obviously does not require either E or S to use a lethal 'device' to end S's life, since S will die due to his condition if treatment is not provided or withdrawn. Rather, S desires that E does not obstruct his dying process. For example, S might desire the removal of a pre-existing vital treatment which he authorised previously but now wishes to be withdrawn. English law that requires interference with S's purpose in the "let me die" situation does so by imposing a duty on E to preserve S's life. In English law such a duty arises in a caring or medical context:

> Where one individual has assumed responsibility for the care of another who cannot look after himself or herself, whether as a medical practitioner or otherwise, that responsibility cannot lawfully be shed unless arrangements are made for the responsibility to be taken over by someone else. Thus a person having charge of a baby who fails to feed it, so that it dies, will be guilty at least of manslaughter. The same is true of one having charge of an adult who is frail and cannot look after herself...[1]

However, where a patient refuses vital treatment, and has capacity to do so, the doctor does

[1] *Bland v Airedale NHS Trust* [1993] AC 789, 858 per Lord Keith.

not remain legally responsible to provide it.[2] Refusals can be made contemporaneously to the unwanted vital treatment or in advance (i.e 'living wills' or 'advance decisions,').[3] Where a doctor acts in accordance with a patient's valid refusal of vital treatment her conduct is not considered to be within the offence of assisted suicide.[4]

The chapter will firstly consider the scope for legal refusal of vital treatment. The influence of the sanctity of life doctrine upon legal distinctions concerning intention/motive and action/omission will be examined briefly (see 8.2.1) and then the scope of English law on refusal of vital treatment will be set out (8.2.2) and evaluated under the PGC (8.2.3). The chapter will secondly establish in outline the scope for safeguards against incompetent (suicidal) refusal of vital treatment (8.3). This outline will include regulation of capacity (8.4), voluntary and informed refusals (8.5, 8.6), as well as regulation of advance refusals under the Mental Capacity Act 2005 (8.7). The chapter will conclude by evaluating the compatibility of a legal permission for valid refusals in the "let me die" situation with a near-absolute prohibition of assisted suicide.

8.2 The scope for refusal of vital treatment

8.2.1 Moral background to suicidal refusals of vital treatment

Before examining the legal basis for suicidal refusals of vital treatment it is useful to understand its moral basis and its relationship with enabled suicide. The characterisation of refusal of vital treatment as a form of enabled suicide is controversial and is rejected on the theorised sanctity of life view considered in the previous chapter (eg Keown 2012, 140*ff*.). This view is also reflected in judicial reasoning on refusal of vital treatment.[5] However, as Lady Hale pointed out in *Nicklinson* as regards *Re B*,[6] a case of withdrawing mechanical ventilation discussed further below (8.2.2), refusal of vital treatment cannot always be

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[2] *Ibid*, 798 per Lord Goff.
[3] The Mental Capacity Act 2005 sets out criteria for the validity of advanced refusals that go beyond the criteria for valid contemporaneous refusals (ss24-26; see further 8.7).
[4] *Airedale NHS Trust v Bland* [1993] AC 789 at 814.
[5] *Ibid.*
[6] *Re B* [2002] EWHC 429.

meaningfully distinguished from a suicidal act.[7] In *Re B* Dame Butler-Sloss found that the principle of self-determination must prevail over that of the sanctity of life in the context of withdrawal of vital treatment.[8]

The legal and moral distinctions informing Dame Butler-Sloss's statement as regards the sanctity of life in *Re B* are not straightforward. The theorised sanctity of life position accepts a distinction between a moral duty to comply with suicidal requests to refuse vital treatment, which is impermissible, and a limitation placed on the moral duty to preserve life, which is permissible (if the rule against *intentional* killing is respected). The latter situation, as discussed in the previous chapter, arises when the preservation of life is no longer viewed as being in the patient's best interests. There are two over-arching reasons for the justifiability of a limitation on the duty to preserve life under the theorised sanctity of life position: the first is that burdensome vital treatments might be withdrawn or withheld on the basis that so doing has the primary intention of relieving the patient of pain created by treatment (eg Keown 2012, 145); the second is that doctors are not necessarily morally responsible for all deaths which they could have prevented had they acted, as this would impose an unfair burden on doctors (Keown 2012, 112). This section examines the influence of the second reason in particular (the first reason invokes the principle of double effect (PDE) which was considered at length in 7.2).

A general distinction between the moral import of an agent's voluntary action, as opposed to an agent's voluntary failure to act to save another, is accepted within the duty-based theory that provides the foundation for the sanctity of life stance considered in this thesis (Finnis 2011, 195-96).[9] A similar limitation is recognised under the PGC although, as discussed in chapters 2-5, the instrumental value of life as a generic condition of agency means that there is no duty to interfere with a suicidal agent's competent decision. The duty to rescue in both theories is therefore non-absolute as a practical moral requirement.

The limitations of the duty to preserve life will be explained in terms of the person requesting

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[7] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [301-304].
[8] *Re B* [2002] EWHC 429 [27].
[9] See generally eg Pattinson 2014, 15-006.

suicide (S), and the official empowered to interfere (O), for convenience. The 'enabler' (E) in this scenario is a medical professional in a position to preserve S's life through treatment, who could enable S's suicide if she refrained from action to preserve his life. There are two broad limitations on E's duty recognised by duty-based theory and the PGC. Firstly, and most straightforwardly, her duty is limited where E is incapable of acting to rescue S. In particular, resources may not be made available to E to enable her to act to interfere. Secondly, E is only required to make a 'good faith' judgement in her circumstances as to whether preserving S's life is reasonably possible and required in S's best interests (eg Keown 2012, 145).

It is argued that there is potential for a limited degree of agreement between the theorised sanctity of life position and the PGC as regards the permissibility of E withholding vital treatment from S on the basis of the above criteria. These criteria apply in situations familiar to the medical context, and these applications are expanded on briefly in order to illustrate the scope for agreement between the sanctity of life position and the PGC in relation to the limits on E's duty to treat. The first criterion considered above, of E's capacity to provide vital treatment, is particularly relevant in the following situations: when she cannot compel S to undergo treatment; when she is responding to an emergency, or where medical resources are not available (Keown 2012, 144). To elaborate upon the latter situation, medical institutions allocate scarce resources to different categories of patient on various criteria, which may be challenged in themselves; however, in terms of E's duty, the position is straightforwardly that where resources are not available to treat S she has no duty to do so (eg Keown 2006; Keown 2012, 144).

The second criterion considered above finds that E's responsibility is limited by her ability to judge reasonably that vital treatment is in S's best interests (Keown 2006, 111*ff*.). The doctor's judgement cannot amount to one that *death* is in S's best interests, but she could arrive at such a judgement where S is suffering and dying, and further treatment would not be in the patient's interests (Keown 2012, 142*ff*.). The justifiability of E's judgement is based on the principle of double effect, discussed in 7.2, since the primary intention must not be to end S's life but rather to make a decision about his treatment (Keown 2012, 143). The nature of such an assessment is necessarily sensitive to S and thus it is justifiable not to require E to provide vital treatment in a broad range of cases where S's best interests could reasonably be judged not to be served by such treatment. On this basis it is justifiable for E to have an

absolute discretion to judge whether to accept S's refusal of vital treatment. A theorised sanctity of life view can therefore justify legal requirements that permit S's refusal in a broad range of situations, particularly as regards 'end of life' treatment, but a *righ*t to refusal of vital treatment is not justifiable (Keown 2012, 145).

The criteria discussed above represent different themes in terms of the PGC and duty-based theory: firstly, duties of care are necessarily limited by E's capacity to act (Gewirth 1978, 217*ff.*); secondly, duties of care must accommodate E's reasonable judgement about the relevant condition of S (Gewirth 1978, 225-26). The recognition by Dame Butler-Sloss in *Re B*[10] that the principle of self-determination must prevail over that of the sanctity of life therefore does not straightforwardly equate to a judgement that suicidal requests should be permitted in the context of vital treatment in contradiction to the theorised sanctity of life stance.[11] Such requests may permissibly be acceded to by E without implying a rights-based judgement that her decision is based on S's suicidal desire. However, in certain situations where E's judgement is decisive, her decision to uphold S's request does contradict the sanctity of life approach. In particular, in the case of withdrawal of ongoing vital treatment, E's decision cannot plausibly be based on her inability to act to fulfil her duty of care, since the treatment has already been, or is being, provided to S. The decision to withhold treatment from a currently incapacitated patient (who has expressed his refusal previously) is similar, to an extent, in that E is required to act on her own judgement without S's participation.

The phenomenon of suicidal treatment refusal applied to modern technologies that create inexpensive, ongoing life-preserving treatments creates an ethical dilemma for sanctity of life theorists since they would want to avoid eliding such refusal with enabled suicide, but struggle to justify the refusal of treatment on the basis of the principle of double effect. This is because for such a theorist, the suicidal purpose must not be taken into account (Keown 2002, 66-68; see also 2.4), but refusing to take it into account would mean that there was little reason not to continue to provide the treatment. The influence on English law of the sanctity of life principle as regards refusal of vital treatment is somewhat similar to the role of such a principle on the doctrine of 'life-shortening treatment' discussed in 7.2. However, a

[10] *Re B* [2002] EWHC 429.
[11] *Ibid* [27].

significant divergence between the sanctity of life principle of double effect justification for refusal of burdensome vital treatment, and English law, has emerged since legal permissibility is based primarily on the fact that refusal requires an *omission* by doctors/carers rather than an action.

8.2.2 The limitation to enabled suicide by refusal of vital treatment in English law

In 1993 the House of Lords in *Bland* addressed itself to the question of whether withdrawing vital treatment from a patient in a permanent vegetative state was equivalent to 'killing' and the patient had provided no indication as to whether he would have refused such treatment in his situation.[12] The *ratio* of *Bland* as it relates to human ostensible non-agents is not relevant to this thesis; however, the decision provided legal confirmation for the justifiability of finding no legal duty for a doctor to continue to preserve life where there was a (valid) refusal of vital treatment in English law.[13] Their Lordships sought, further, to distinguish permission for such refusal from the impermissibility of euthanasia and assisted suicide. They also generally addressed the relationship between requested withdrawal of vital treatment and the sanctity of life doctrine.

A preliminary point about English law on refusal of vital treatment in *Bland* is that refusal of medical treatment was contrasted with refusal of 'basic care' (Grubb 2004, 141). However, *clinically assisted* vital care (CAVC) is considered to be permissible in English law on the same basis as refusal of treatment.[14] To elaborate briefly on the nature of distinction: vital care refers to materials immediately necessary to sustain a healthy body: water, air and food in particular; basic care has not been subject to precise legal definition but is likely to encompass a miscellaneous category of environmental factors and material sustenance (such as blankets, but can also, confusingly, include hydration and nutrients)[15] that sustain general levels of wellbeing. Patients receiving ongoing clinically assisted vital care who wish to end their lives require an *action* on another's part to *discontinue* the 'treatment' rather than an omission to treat (eg Jackson 2012, 26*ff.*). As discussed in the previous chapters, English law

[12] *Airedale NHS Trust v Bland* [1993] AC 789.
[13] *Ibid* 859 per Lord Keith.
[14] *Ibid.*
[15] Department of Constitutional Affairs 2014, para.9.28. See also Pattinson 2014, 14-010.

typically treats an *action* causing death or materially assisting suicide as contrary to the sanctity of life principle and impermissible as murder or assisted suicide (although infrequently prosecuted in cases of rational suicide and compassionate enabling action; see chapter 6).

The *Bland* case involved a patient who was receiving CAVC (in the form of full life support) which his relatives sought to discontinue (Bland had not had an opportunity to execute a 'living will,' see below 8.7).[16] In the Court of Appeal[17] in *Bland* Hoffmann LJ appeared to accept an interpretation of withdrawal of ongoing, burdensome, treatment not based on omissions.[18] He found that the basis for permitting the cessation of clinically assisted respiration leading to Bland's death was that:

> In cases when further treatment can prolong the life of the patient only for a short period and at the cost of great pain and suffering, the doctor is under no obligation to continue. I do not think that the distinction turns upon whether what is done is an act or omission…The distinction is between an act or omission which allows an existing cause to operate and the introduction of an external agency of death.

Hoffman LJ therefore accepted the apparent similarity between withdrawal of the feeding tube, and euthanasia, and did not seek to pinpoint the distinction between action or omission. Rather, he found that the distinction was between introducing an 'external agency of death' and relieving Bland of a burdensome treatment (removal of the feeding tube) which served no purpose in Bland's situation. Hoffman LJ sought to create a distinction between the culpability of a doctor who removed the tube because that was perceived to be the best interests of Bland, and *ending Bland's life.* In other words, withdrawal was based on the

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[16] *Airedale NHS Trust v Bland* [1993] AC 789, 817.
[17] *Airedale NHS Trust v Bland* (1992) 142 NLJ 1755.
[18] *Ibid* '…[T]here is concern about ceasing to supply food as against, for example, ceasing to treat an infection with antibiotics. Is there any real distinction? In order to come to terms with our intuitive feelings about whether there is a distinction… Subject to exceptions like self-defence, human life is inviolate even if the person in question has consented to its violation. That is why although suicide is not a crime, assisting someone to commit suicide is. It follows that, even if we think [the patient] would have consented, we would not be entitled to end his life by a lethal injection.'

ending of an inhumane, burdensome treatment, rather than on intention that Bland should die. This principle is cognate with the interpretation placed on the principle of double effect in relation to life-shortening treatment, which is considered in the previous chapter (7.2). Lord Bingham (Master of the Rolls) and Dame Butler-Sloss were explicitly opposed to the application of the PDE in this context, referring to Lord Devlin's judgement in *R v Adams*, in the Court of Appeal; they argued that situations of lethal injection were dissimilar to switching off a ventilator.[19] Lord Browne-Wilkinson, in the majority in the House of Lords, agreed with both Bingham LJ and Butler-Sloss LJ and went further, ruling out any suggestion of relying on the PDE in this context:

> Murder consists of causing the death of another with intent to do so. What is proposed in the present case is to adopt a course with the intention of bringing about [the patient's] death. As to the element of intention … in my judgment there can be no real doubt that it is present in this case: the whole purpose of stopping artificial feeding is to bring about [his] death.[20]

The majority in the House of Lords sought to affirm a distinction, related to refusal of treatment, between 'passively' ceasing to provide vital care and actively ending life:

> …the law draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide, for his patient treatment or care which could or might prolong his life, and those in which he decides, for example by administering a lethal drug, actively to bring his patient's life to an end.[21]

The 'crucial distinction' is not considered to be well-founded; in *Bland* both Lords Browne-Wilkinson[22] and Mustill[23] expressed uncertainty about drawing such a distinction, and the finding is much criticised in academic literature (eg Keown 1997) and subsequent judicial

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[19] *Airedale NHS Trust v Bland* (1992) 142 NLJ 1755, 1759.
[20] *Airedale NHS Trust v Bland* [1993] AC 789 at 881.
[21] *Ibid* at 865.
[22] *Ibid* at 885.
[23] *Ibid* at 887.

comment.[24] The artificiality of the distinction formed part of the claim that the common law on murder should be developed to recognise a defence of necessity applicable to a person killing Lamb on request in the *Nicklinson* litigation[25] (see further 6.3). The characterisation of an action to end the ongoing CAVC in *Bland* as an 'omission' illustrates that English legal doctrine of omissions cannot be justified by duty-based or rights-based moral justifications for such a doctrine. This is not merely because it is conceptually unsound (treating an action as an 'omission'), but also because the doctor's action clearly controls the outcome of the patient's death, as Hoffman LJ observed in the Court of Appeal.[26]

The finding of the majority in *Bland*, although in that instance it was applied to a patient without capacity, is applicable to a refusal of CAVC. Lord Browne-Wilkinson recognised that permitting voluntary withdrawal of vital care represented a challenge to the supremacy of the sanctity of life doctrine, but decided that this was an appropriate development in English law due in part to the increasingly recognised exception to that doctrine based on self-determination as regards refusal of vital treatment.[27] Despite acknowledging that reliance on the principle of self-determination in relation to refusal of treatment was an exception to the sanctity of life principle, the characterisation of compliance by a doctor with a suicidal refusal of treatment as assisted suicide was rejected by Lord Goff:

> …in cases of [refusal of vital treatment], there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so. It is simply that the patient has, as he is entitled to do, declined to consent to treatment which might or would have the effect of prolonging his life, and the doctor has, in accordance with his duty, complied with his patient's wishes…[28]

The reasoning in *Bland* was later applied to a rare case of a clearly suicidal refusal of ongoing

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[24] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [18] per Lord Neuberger.
[25] *R (Nicklinson) v Ministry of Justice* [2013] EWCA Civ 961 [61].
[26] *Airedale NHS Trust v Bland* (1992) 142 NLJ 1755.
[27] *Airedale NHS Trust v Bland* [1993] AC 789 at 887.
[28] *Ibid* 863-864.

vital care which was requested and refused by the healthcare team in the case of *Re B.*[29] B sought to enforce her request by seeking a declaration by the High Court.[30] In other words, the principle from *Bland* was applied in an instance in which the patient had capacity and requested that CAVC be discontinued on the basis of a desire to end her life. Thus the Court found that compliance with such a request was permissible.

The decision to adopt what is essentially a refusal of treatment basis for the outcome in *Bland*, despite the fact that *Bland* was receiving ongoing treatment, had no capacity to resist, and had expressed no advanced decision, is striking. The result of *Bland* has been to create an absolutist doctrine of refusal of vital treatment with capacity which appears to be at variance with a prohibition of assisted suicide designed to protect vulnerable suicidal decision-makers. Recent legislation has sought to restrain the effect of advanced vital refusals of treatment to a limited extent (Mental Capacity Act 2005 s25; see 8.7), but withdrawal of vital treatment is not constrained. The next sub-section (8.2.3) will examine possible defences for the distinctions drawn in English law between actions and omissions under the PGC, and will come to an interim conclusion on the proportionality of the limitations on S's exercise of his generic right to enabled suicide in the "let me die" situation.

8.2.3 Application of the PGC

As discussed above, the requirement to refrain from acting to enable suicide beyond 'non-prolonging' acts/omissions derives from the sanctity of life stance. Legal requirements based upon that stance can be found to be justifiable under the PGC to an extent, as discussed in the previous chapters (see eg 7.2), where they are interpreted as safeguards for competent suicide. Under such an interpretation, a doctor complying with a refusal of vital treatment, including withdrawal of treatment, does intend to facilitate suicide, but it is justifiable to require that his evident motive is neutral as regards the suicidal patient's decision (rather than to encourage his choice, which could amount to influence or pressure, see 7.4). Furthermore, it is justifiable to require that the patient is dying and is suffering in addition to his sincere, competent desire that his treatment should end.

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[29] *Re B* [2002] EWHC 429 [25].
[30] *Ibid*.

The approach in *Bland* and *Re B,* however, does not adopt such a PGC-compatible interpretation of sanctity of life and PDE. In *Re B* the physician was permitted (in fact required) to enable B's suicide by refusal of vital treatment merely on the basis of B's signalled desire and the judgement that she had 'capacity' (see further below, 8.4). The 'exception' to the sanctity of life principle in English law based on refusal of vital treatment so that a suicidal patient can enforce a request for withdrawal regardless of his condition, has created narrow, but explicit, recognition for the generic right to enabled suicide. This explicit recognition may be characterised in terms of a refusal of a non-life prolonging 'device' (i.e. an object designed to fulfil a purpose, eg a medicine or ventilator; see also chapter 5, 5.4.2).

The scope for exercise of the generic right to enabled suicide by refusal of vital treatment in the "let me die" situation may be set out in the following terms:

> The suicidal claimant (S) seeks to exercise his right by signalling his refusal of a life-prolonging 'device' to the enabler (E) and an official (O). The enabler (E) is a doctor who is under a duty to provide such a 'device' in S's best interests unless S refuses such treatment. The official (O) is a judge who is empowered to interfere with E's action by requiring E to treat S as per E's duty. S may exercise his right by requiring that O does not interfere with E. The refusal of the life-prolonging 'device' may be given effect to by an action of withdrawal or an omission. The life-prolonging 'device' may not be non-clinical (i.e. not basic care).

The limitations on the generic right to enabled suicide by refusal of vital treatment that require justification are therefore straightforwardly reliant on the conduct (omission or withdrawal) and the setting (medical). The distinction drawn between a clinical setting and a non-clinical setting is defensible on the basis that the latter does not benefit from institutional oversight of signalling (eg record keeping; see further 7.4).

The restriction upon S's generic right to enabled suicide in the "help me die" situation to conduct that gives effect to the refusal by an action of withdrawal or omission is not straightforwardly defensible under the PGC. The limitation to an omission and 'withdrawal'

category of justifiable lethal conduct is broadly regarded as an irrational position, as discussed above. This limitation appears to be straightforwardly irrelevant to the aim of establishing competence. However, it is argued that a limitation to omission/withdrawal is capable of justification, to an extent, on similar grounds to the justifiability of the PDE applied to life-shortening treatment. There are two broad possible bases for such a justification: firstly, where withdrawal/omission indicates that the patient's condition is one of extreme suffering; secondly where omission indicates that the patient has control over the suicidal action. The first applies to cases of withdrawal such as that in *Re B*, but does not apply to all cases of suicidal refusal of treatment (eg a suicidal refusal of a blood transfusion in *Re T*).[31] The second typically applies to cases of refusal, such as Tony Nicklinson's decision to die by refusal of food (BBC 2012b), but does not apply to cases of withdrawal such as *Re B*.

Firstly, as was discussed in the previous chapter, extreme suffering associated with dying can form a medically evidenced 'good' reason[32] for the suicidal potentially incompetent agent's (PIA's) decision, which is relevant to a potentially justifiable restriction upon claims to enabled suicide. In particular, extreme suffering and dying are conditions that, if sufficiently evidenced, demonstrate that the suicidal PIA reasonably understands the capacity for treatment to remedy his current condition. However, while refusal of life-prolonging treatment in the context of extreme suffering and dying is the most prevalent context for refusal of vital treatment (eg Griffiths 2008, 488*f*.), it is obviously not the only situation in which refusal can occur. Vital treatments can be applied to restore a person to health, such as blood-transfusions, or alternatively clinically maintain life, such as pace-makers. The category 'treatment refusal' is broader than necessary to establish that the suicidal PIA has a 'good reason' to commit suicide.

Secondly, refusal of vital treatment is a form of suicide that maintains the patient's control over the final, killing, act. The temporal/physical separation of the enabler from the ultimate suicide demonstrates that he lacked the capacity to interfere with that act (see relevant

[31] *Re T* [1992] WLR 782.
[32] Such a reason is one that is capable of being weighed against the continuation of his agency; see the framework in 5.3.2.

potentially justifiable restrictions upon claims to enabled suicide as regards signalling in 5.4.2). Thus, where refusal results in a dying process that creates temporal or physical distance between the enabling action and the resulting death, this is generally sufficient to establish the suicidal PIA's control over that act. However, not all circumstances of refusal result in a dying process that provides evidence of such separation. The withdrawal of ongoing clinically assisted vital care (CAVC), especially mechanical ventilation, is an example of refusal in which the dying process is typically almost instantaneous from the point of the enabling action of removing the ventilator. Similarly, an advanced decision to withdraw treatment which is to be put into effect when the suicidal PIA is unconscious does not demonstrate his control over the suicidal act.

As regards the direct application of the PGC the limitation to refusal of vital treatment is not justifiable since there is no necessary relationship between the category 'refusal of vital treatment' and competent suicide. In order to determine whether the law on refusal of treatment arbitrarily discriminates between forms of "let me die" claim it is necessary to determine the scope of claims that are capable of falling within a relevant category in terms of the PGC. The restriction to 'refusal of vital treatment' as a category might be justified under the indirect application of the PGC (4.5.3) on the basis that drawing distinctions between different refusals represents an administrative burden that exceeds the government's minimal responsibility to secure the generic right to enabled suicide. However, a temporal/physical distinction between the enabling act and the final act of suicide is straightforward and, as Lord Neuberger stated in *Nicklinson*, already recognised in law.[33]

It is submitted that in the absence of an indirect justification of a general category of refusal of vital treatment a new category should be adopted which covers firstly, refusals of vital treatment by omission where the patient is competent to control his suicide, and secondly, refusals of vital treatment by omission where the patient is not competent to control his suicide and withdrawal of vital treatment where the patient cannot act to control his suicide. It is arbitrary to distinguish between "let me die" claims on the basis that the nature of the action is lethal treatment, rather than withdrawal/omission in the second category, and so

[33] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [92-94].

doing is therefore a violation of the generic right to enabled suicide.

The lack of a justificatory rationale for refusal of *burdensome* vital treatments (where the patient is suffering and dying) means that the justificatory basis for advance refusals and withdrawals is straightforwardly *competent suicide*. The case of *Re B* demonstrated that relevant institutional support was available to assess competence for this narrow form of physician-enabled suicide. The case of *Re B* amounts to a judgement that judges are capable of making such an assessment, as Lady Hale recognised in *Nicklinson*. The nature of this assessment in law is considered in the next section.

8.3 English legal framework restricting the "let me die" claim

As discussed above, only a valid refusal of vital treatment or clinically assisted vital care (CAVC) relieves a doctor of her duty of care. A doctor who proceeds to treat despite a valid refusal could incur liability under the tort of battery or be prosecuted for the crime of assault.[34] A doctor who fails to treat where the patient has given an invalid refusal could possibly incur liability under the tort of negligence[35] or even be prosecuted for gross negligence manslaughter.[36] Furthermore, a doctor who withdraws vital treatment/CAVC on the basis of an invalid refusal could also be prosecuted for manslaughter or murder.[37] The protection for contemporaneous refusals is necessarily limited and there have been no successful prosecutions of a doctor in relation to refusal of vital treatment.[38]

Dame Butler-Sloss set out the approach to valid refusal of vital treatment as follows:

> A mentally competent patient has an absolute right to refuse to consent to

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[34] *Freeman v Home Office (No 2)* (1984) 1 QB 524; *Re T* [1992] WLR 782; *R (on the application of H) v Mental Health Review Tribunal* [2007] EWHC 884.
[35] *Sidaway v Bethlem Royal Hospital* [1985] AC 871 at 876.
[36] *R v Adomako* [1995] 1 AC 171 at 187.
[37] *Airedale NHS Trust v Bland* [1993] AC 789 at 836.
[38] A contemporaneous suicidal refusal is unlikely to give rise to liability, since 'when there is doubt whether an apparent refusal of consent is valid in circumstances of urgent necessity, the decision of a doctor acting in good faith ought to be conclusive' *Re T* [1993] Fam 95 at 122.

> medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death…[39]

There is a legal presumption that a refusal of vital treatment is valid where the patient has capacity to make such a decision in terms of the Mental Capacity Act (MCA) 2005 s2 (8.4).[40] The patient's refusal (with capacity) may be disregarded if she reasonably judges him to be acting under coercion/influence (8.5). A doctor should seek to ensure that her patient has the necessary information enabling him to make his decision, as to, in particular, his condition and alternative treatment,[41] but she may not disregard his refusal on the basis that he is uninformed (8.6). Advanced decisions to refuse vital treatment/CAVC are given effect to in law on the same basis as contemporary refusals (MCA 2005 s26(1)); the MCA 2005 provides a legal framework for the doctor's evaluation of such decisions in terms of their validity and applicability (8.7). The general outline of the legal position will be evaluated below in 8.4-8.7 in terms of the PGC (under the framework set out in chapter 5).

8.4 Capacity

8.4.1 Introduction

If a doctor is to ignore her patient's refusal of vital treatment/CAVC lawfully then she is required to arrive at a reasonable judgement (on the balance of probabilities) to the effect that his refusal lacks capacity (MCA 2005 s5(1),(2)). The doctor is furthermore entitled to deprive the patient of his liberty in order to administer vital treatment/CAVC if she is 'authorised' to do so by virtue of a pending application to the Court of Protection to determine his capacity to refuse (MCA 2005 s5 (1)(b)(ii), s4A, s4B, s16(2)(a)).[42] Children and young people under 16 are not within the MCA 2005 framework determining capacity to refuse vital treatment (exercise of the generic right to enabled suicide by minors is beyond the scope of this thesis).

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[39] *Re MB* [1997] 2 FLR 426 at 432.
[40] Where a patient is judged to lack capacity when they refuse treatment the doctor remains under a duty to treat the patient if that is judged to be in their best interests (s4 MCA 2005; *Re T* [1993] Fam. 95, 115-116).
[41] *Pearce v United Bristol Healthcare* (1999) PIQR 53 [21].
[42] This thesis is not concerned with patients compulsorily detained under ss 2, 3, 56 of the Mental Health Act 1983, since such persons clearly lack the mental ability necessary for *rational* suicide (see 1.2.4).

The legal principles that provide the foundation for a doctor's evaluation of capacity under the MCA 2005 include: a presumption that the patient has capacity (s1(2)); support for his decision-making where 'practicable steps' can be taken in order to enable him to attain capacity (s1(3)); a presumption that the doctor cannot infer incapacity merely because she deems his decision to be 'unwise' (s1(4)). These principles are applied to a two-stage test under s2(1):

> …in relation to a matter… at the material time he is unable to make a decision for himself in relation to the matter because of an impairment[43] of, or a disturbance in the functioning of, the mind or brain.

Firstly, lack of capacity can only be inferred[44] where there is an impairment or disturbance in the functioning of the mind or brain (see 8.4.3). The Act also makes it clear that age, appearance, medical condition or behaviour are insufficient on their own to infer incapacity (s2(3)(a),(b)). Secondly, a patient is 'unable to make a decision for himself': where he is unable to understand the information 'relevant to the decision' (s3(1)(a)); retain [the information] (s3(1)(b)); use or weigh that information as part of the process of making the decision (s3(1)(c)); or is unable to communicate his decision (s3(1)(d)) (see 8.4.4). Before considering the application of these tests it is useful to elaborate upon the legal background to the MCA 2005 (the High Court's exercise of its inherent jurisdiction over vulnerable individuals).

8.4.2 Overview of English law on capacity to refuse vital treatment/CAVC

Prior to the MCA, in *Re T*, Lord Donaldson sought to increase legal protection for 'vulnerable' individuals making vital refusals by raising the level of 'capacity' needed to make such a decision:

> Doctors faced with a refusal of consent have to give very careful and detailed

[43] The impairment can be temporary or permanent MCA (s2(2)).
[44] On the balance of probabilities MCA (s2(4)).

> consideration to what was the patient's capacity to decide at the time when the decision was made. It may not be a case of capacity or no capacity….What matters is that the doctors should consider whether at [the relevant time] he [the patient] had a capacity which was commensurate with the gravity of the decision which he purported to make. The more serious the decision, the greater the capacity required…[45]

Pattinson has termed such an approach a 'risk-relative' conception of capacity, since the level of 'capacity' required is relative to the risk posed to the vulnerable decision-maker (2006, 137-38). A plausible interpretation of Lord Donaldson's finding is that by 'capacity' he was referring to the level of decision-making *competence* that a person must demonstrate, since, by definition, a 'capacity' cannot vary. It was not entirely clear from *Re T* itself what the *level* of decision-making competence for refusal of vital treatment should be. In particular, it was unclear whether the self-harm involved in such a decision would be such that certain people, for example persons with a history of depression, could not achieve such a level.

Lord Donaldson's approach has not been adopted in general as regards capacity; subsequent decisions have referred to the need for a doctor to employ a neutral capacity test that avoids judging the 'gravity' of the patient's decision.[46] Mr Justice Charles summarised these points in the case of *X NHS Trust v T*:[47]

> The view of the patient may reflect a difference in values rather than an absence of competence and the assessment of capacity should be approached with this firmly in mind. The doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient to cloud their judgment in answering the primary question whether the patient has the mental capacity to make the decision.[48]

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[45] *Re T* [1993] Fam 95 [113], [115-116]. The approach was confirmed by the Court of Appeal in *Re MB* [1997] 2 FLR 426, 437. Lord Donaldson's phrasing is unfortunate, since by definition a person's capacity cannot vary (Pattinson 2006, 137).
[46] Eg *X NHS Trust v T* [2004] EWHC 1279; *Newcastle Upon Tyne Hospitals Foundation Trust v LM* [2014] WL 1220013.
[47] *X NHS Trust v T* [2004] EWHC 1279.
[48] *Ibid* [100].

The fact that a refusal of treatment is suicidal is therefore not a sufficient reason upon which to base a finding that a person lacks capacity.[49] The lack of explicit differentiation of approach between refusal of vital treatment/CAVC and other treatments is criticised for failing to provide a sufficient safeguard against incompetent suicidal refusals (Jackson 2012, 19*ff*.).

The approach of the courts to capacity to refuse vital treatment immediately prior to the MCA is illustrated by the case of *Re B.*[50] In this case the tetraplegic claimant, disappointed by the limited prospects of recovering body function, requested that her ventilator be switched off.[51] In Ms B's case she evidenced her decision in writing multiple times and was examined by competent psychiatrists on three separate occasions to confirm that she was not suffering from depression or other mental impairment leading to her decision to commit suicide by withdrawal of CAVC.[52] Ms B showed little ambivalence: she demonstrated a steadfast commitment to her determination to end the artificial ventilation that was keeping her alive, even pioneering the action against the hospital trust and proving an extremely competent witness.[53] She was judged to have capacity and it was found to be permissible to switch off her ventilator.

8.4.3 The first stage test: impairment or disturbance in the mind or brain

The definition of 'impairment or disturbance in the mind or brain' (MCA s2(1)) clearly encompasses 'mental illness'.[54] However, suicidal behaviours associated with extreme states of mental disorder are not considered in this thesis, since they are manifestly distinguishable from the rational/purposive behaviour associated with competent suicide (the behaviour of a rational agent, as defined in 1.2.4). Marginal cases of incompetence, such as depression or personality disorder, are plausibly relevant to the safeguards against incompetent suicide considered in chapter 5 (see 5.6). The current approach of the Court of Protection indicates

[49] *Ibid.*
[50] *Re B* [2002] EWHC 429.
[51] *Ibid* [38-39].
[52] *Ibid* [7].
[53] *Ibid* [53] per Dame Butler-Sloss.
[54] Eg *L v J* [2010] EWHC 2665.

that a patient must generally demonstrate at least evidence of psychotic mental illness (i.e. delusions or hallucinations) to fall within s2(1) (on grounds of mental illness).

A recent example of the operation of the first stage test in the context of refusal of vital treatment is provided by *Nottinghamshire Healthcare NHS Trust v J*.[55] J sought to make an advance decision to refuse a blood transfusion on the basis that he was a Jehovah's Witness. However, J suffered from a severe personality disorder which caused him to engage in behaviour of 'significant self-harm through self-laceration and bloodletting'.[56] The suicidal implications of such an advance decision were therefore manifestly apparent. In an interim holding, J's decision was found to be made with capacity. Mr Justice Holman found as follows:

> As I understand it, it is not the opinion of the treating psychiatrist that he suffers from any kind of delusions or delusional disorder. His intelligence is within the range of normal and he appears (although this may require further exploration) to have capacity… to make decisions with regard to his medical treatment…[57]

The published finding in *J* is merely an interim finding; Mostyn J's substantive judgement[58] is unpublished, but upheld the patient's right to refuse vital treatment (Munro 2014).

Another recent example is provided by *Newcastle Upon Tyne Hospitals Foundation Trust v LM*[59] in which the claimant, also a Jehovah's Witness, adamantly refused a vital blood transfusion. It was found that there was no evidence of psychotic illness despite some confusion at the point of her decision. On this basis it was found that it would be lawful to withhold the transfusion.

An example of the Court of Protection taking, arguably, a more expansive approach to

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[55] [2014] EWHC 1136 (COP).
[56] *Ibid* [2].
[57] *Ibid* [2].
[58] On 24th May 2014, Munro 2014.
[59] [2014] WL 1220013.

incapacity is provided by the case of *A local Authority v E*.[60] This case concerned an individual who suffered from particularly severe anorexia and sought to refuse life-preserving treatment/CAVC (in the form of nutrition). In addition to her anorexia she was found to have a personality disorder and significant dependence on alcohol and opiates.[61] It was found, briefly, that E fell within the MCA on the basis that her severe anorexia constituted a disturbance in the functioning of her mind.[62] This judgment reflects the Code of Practice to the Mental Capacity Act (Department of Constitutional Affairs 2014, para 4.22) which finds that 'a person with anorexia nervosa may lack capacity in relation to some decision'.[63] The decision in *E* has not been subject to appeal or further consideration by a higher court. Even if this decision is upheld it is likely that a personality disorder will not be enough on its own to deny capacity to make suicidal refusals of vital treatment/CAVC (eg Szmuckler 2009). It is argued by those critical of the *E* judgement that E's severe anorexia indicated only that she was suffering from a condition that radically distorted her perception of eating (Coggon 2014; see eg as regards anorexia generally, Draper 1998, 5).

8.4.4 The second stage test for capacity: ability to make a decision

The second stage test finds that if the patient is to 'make a decision' deemed valid to refuse vital treatment/CAVC, then it is necessary for his decision to be scrutinised to determine whether he understands the consequence of his refusal (MCA s2(1),s3).[64] Under s3(1)(a) he must be able to retain the relevant information and under s3(1)(b) be able to understand it. A patient with capacity may understand the choice when it is 'broken down' and be able to choose in general, but he may be 'overwhelmed' by his decision and in that sense may lack capacity.[65] This requirement is especially pertinent to refusals of vital treatment, due to the enormity of the decision.

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[60] *A local authority v E* [2012] EWHC 1639.
[61] *Ibid* [107].
[62] *Ibid* [48].
[63] See also Lord Donaldson's judgment in the case of *Re W* '… it is a feature of anorexia nervosa that it is capable of destroying the ability to make an informed choice. It creates a compulsion to refuse treatment or only to accept treatment which is likely to be ineffective. This attitude is part and parcel of the disease and the more advanced the illness, the more compelling it may become.' *Re W* (1992) 4 All ER 627 at 637.
[64] *X NHS Trust v T* [2004] EWHC 1279 [295]. Death is obviously a 'reasonably foreseeable consequence' of withdrawal of vital care within s3(4) MCA.
[65] *A Local Authority v F* (2011) EWHC 3932 [17].

The s3 criteria were considered in the case of *E* (considered above), which concerned the refusal of vital nutrition by a severely anorexic patient. E was found to be able to retain and understand information as regards her decision and thus fulfilled the s3(1)(a) and (b) criteria.[66] However, Ms E was ultimately found to lack capacity to make the decision to refuse vital treatment/CAVC, in the form of food, on the basis that her anorexia interfered with her ability to rationally reflect upon her own interests as regards the vital care (MCA 2005 s3(1)(c)).[67] The basis for this finding was that her anorexia created a particular lack of capacity as regards the vital care in question (nutrition) despite the fact that in general she satisfied the capacity conditions.[68] Her drug and alcohol use were considered to be secondary reasons for the finding as to her lack of capacity, on the basis that they were generally deleterious to her ability to engage in rational reflection.[69]

The decision in *E* has been criticised as an interpretation of the wording of s3(1)(c) MCA 2005 on the basis that in terms of E's own perception of her interests she was able to use or 'weigh' the information, and on the basis that the section does not refer to the capacity for '*rational* reflection' on her interests (eg Hayes 2012; Richardson 2013, 90-91; Coggon 2014, 216-17). These criticisms adopt a minimalist account of the assessment of self-regarding decisions relevant to the s3(1)(c) test. On such an account it is argued that clinical/judicial enquiry should be limited to a formal assessment of capacity that avoids challenging a patient's expressed preferences (eg Freyenhagen and O'Shea 2013, 61).

8.4.5 Conclusion and application of the PGC

The MCA 2005 provides a minimal safeguard against incompetent suicide. As discussed in chapter 5 as regards safeguards against 'depressed' or non-self-regarding suicide, a suicidal potentially competent agent who suffers from a disorder which impairs his ability to *perceive* his condition would clearly be incompetent to exercise his generic right to enabled suicide

[66] *A local authority v E* [2012] EWHC 1639 [48].
[67] *Ibid* [49-51].
[68] *A local authority v E* [2012] EWHC 1639 [49].
[69] *Ibid* [52].

(see eg 5.2.4, 5.2.5). Under the dialectically necessary framework, for S to be considered to be dispositionally/occurently competent to undergo enabled suicide his condition must dispel reasonable doubts by officials (O) as to his ability to weigh the condition against the continuation of his agency. This was found to require S to demonstrate to O that he had assessed his condition in light of his generic interests (see 5.2.3). The approach in *E* is therefore a justifiable limitation on the exercise of the right to enabled suicide as regards the withdrawal of vital treatment/CAVC, since E was clearly unable to weigh her reason for suicide (i.e the refusal of food) against the continuation of her agency, due to her anorexia. However, it is likely that the approach in *E* represents a relatively high threshold for capacity under the MCA 2005, which merely requires that a patient is (dispositionally/occurently) able to take account of his condition and the result of his refusal.

It is useful to compare the capacity test for suicidal refusal of treatment with the example of Nathan Verhelst's enabled suicide under the Belgian euthanasia law, which was widely reported to be a 'controversial' case in international media (BioEdge 2013; see further at 5.6.2). This case involved a transsexual man with a history of neglect and social exclusion caused by his condition. He sought to undergo enabled suicide shortly after a failed operation to complete his physical transition, which had, he said, turned him into 'a monster'. He did not suffer from a personality disorder, but it was clear that his condition and experiences were likely to have exaggerated his perception of the impact of the failed operation on the continuation of his life. Had Nathan's enabled suicide been conducted by refusal of vital treatment under the MCA then his decision would have been accepted implicitly and with no additional safeguards (see 9.3 for discussion of safeguards in regimes that permit enabled suicide).

8.5 Voluntary decision

Lack of capacity to make the decision to refuse vital treatment is not the only possible basis for lawful interference with the hypothetical suicidal claimant's (S's) right to enabled suicide. There is limited legal provision covering denial of validity to vital refusals that are pressured. The test for undue influence in the context of suicidal refusal of vital treatment was set out in

the case of *Re T*.[70] In that case a suspicion was raised over the authenticity of a patient's decision which was made directly after an intervention by her mother (a devout Jehovah's witness).[71] Staughton LJ commented as regards the relevant test:[72]

> …every decision is made as a result of some influence: a patient's decision to consent to an operation will normally be influenced by the surgeon's advice as to what will happen if the operation does not take place. In order for an apparent consent … to be less than a true consent…there must be such a degree of external influence as to persuade the patient to depart from her own wishes, to an extent that the law regards it as undue.

The degree of influence must be such as to outweigh the normal presumption that a refusal of treatment with capacity is to be treated as an autonomous decision, and the burden of proof is upon the party claiming undue influence.[73] The failure to develop a doctrine of undue influence in the medical context, as has been developed in the context of equity,[74] has been criticised due to the particular vulnerabilities of a patient to medical influence (see eg Pattinson 2002b, 310-11; Beyleveld and Brownsword 2007, 167).

Lord Donaldson sets out the essence of the test in *Re T*[75]:

> The real question in each such case[s] is "Does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself?" In other words "Is it a decision expressed in form only, not in reality?"[76]

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[70] *Re T* [1993] Fam 95.
[71] *Ibid* 99.
[72] *Ibid* 121.
[73] *Centre for Reproductive Medicine v U* [2002] EWHC Civ 565 [20].
[74] As regards examples of gifts made by vulnerable individuals to persuaders in a position to exercise powerful influence, such as religious influence; this is particularly the case in probate cases (see eg *Allcard v Skinner* (1887) 36 Ch.D. 145; *Re T* [1993] Fam 95 [24]).
[75] *Re T* [1993] Fam 95.
[76] *Ibid* 113.

Obviously in this context it is firstly necessary to establish that some pressuring action has occurred. The degree of pressure that must be demonstrated is not defined precisely and there is a degree of equivocation in the available precedents. An example is provided by the *U*[77] case. This case concerned written consent for the use of sperm post-posthumously; a request that the patient should deny authorisation for such use was made by nursing staff alongside the implication that desired treatment would be suspended if the requested consent was not given. The pressuring request by the staff was made contemporaneously with U's action of denying authorisation (by altering the consent form).[78] The pressure was accepted to be 'considerable' on this basis.

Secondly there are two key further factors recognised as demonstrating that the pressure was capable of overwhelming the will of the patient: the strength of will of the patient and the nature of the relationship with the persuader.[79] Lord Donaldson in *Re T* emphasised that criteria relating to strength of will were not susceptible to exact definition, but that 'one who is very tired, in pain or depressed will be much less able to resist having his will overborne than one who is rested, free from pain and cheerful'.[80] In *U* Lady Justice Butler-Sloss found 'it is difficult to say that an able, intelligent, educated man of 47, with a responsible job and in good health, could have his will overborne to the extent that Mr U no longer thought and decided for himself', despite the 'considerable' pressure placed upon him by the nursing staff.[81]

The restriction upon valid refusal on the basis of undue influence could form the basis of a judgement that a suicidal refusal of treatment was invalid, as occurred in *Re T*. However, the development of the doctrine after Lord Donaldson's judgment has, in a manner similar to the development of capacity, favoured a presumption of patient autonomy which restricts the scope of the doctrine. It is possible that pressuring a *suicidal* refusal of treatment could amount to encouraging suicide under the Suicide Act 1961 s2. Therefore, while undue influence is a plausible basis upon which a suicidal refusal could be disputed by a doctor or a

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[77] *Centre for Reproductive Medicine v U* [2002] EWHC Civ 565.
[78] *Centre for Reproductive Medicine v U* [2002] EWHC Civ 565 [19].
[79] *Re T* [1993] Fam 95 113-114.
[80] *Ibid* 114.
[81] *Ibid* 114.

court, the restricted scope of the doctrine, and the degree of indirect protection against pressure, means that it is unlikely to be able to exclude a pressured refusal. In other words, it adds little to the protection available.

8.6 The sufficiently informed patient

The 'insufficiently informed' patient is not considered to lack capacity in terms of the MCA 2005 s2(1). The MCA merely requires the patient to be *able* to weigh and understand relevant information rather than that he must be informed as to what the relevant information could be. Official regulation of negligent non-disclosure of information relevant to treatment options could nevertheless provide a measure of guidance as to a medical team's legal obligation to comply with a request for refusal of vital treatment/CAVC. There is no case-law directly concerning an insufficiently informed refusal of treatment/CAVC. An analogy could be found with cases of a failure to disclose risks associated with a course of treatment, the basis of which is an assessment of whether the patient gave 'informed consent' to invasive treatment. The basis of informed consent to invasive medical procedures is that there is 'a significant risk which would affect the judgment of a 'reasonable doctor taking account of the reasonable patient'.[82] The current test, set out in *Pearce*, is as follows:

> the doctor, in determining what to tell a patient, has to take into account all the relevant considerations, which include the ability of the patient to comprehend what he has to say to him or her and the state of the patient at the particular time, both from the physical point of view and an emotional point of view. There can often be situations where a course different from the normal has to be employed. However, where there is what can realistically be called a 'significant risk', then… the patient is entitled to be informed of that risk. [83]

However, the focus of such negligence actions is damage incurred *during* treatment, especially surgery. The GMC has provided further guidance:

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[82] *Pearce v United Bristol Healthcare* (1999) PIQR 53 [22, 23]; confirmed in *Chester v Afshar* [2004] UKHL 41 [15] (HL).
[83] *Ibid*.

> The doctor uses specialist knowledge and experience and clinical judgement and the patient's views and understanding of their condition, to identify which investigations or treatments are clinically appropriate and likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, burdens and risks of each option.
>
> The starting point for reaching good decisions is careful consideration of the patient's clinical situation... [The doctor] must carry out a thorough assessment of the patient's condition and consider the likely prognosis. It can be difficult to estimate when a patient is approaching the end of life, and you should allow for a range of possibilities when planning care…[84]

The guidance also states that doctors must seek an independent second opinion on treatment where there is disagreement over treatment options with the patient, his relatives or other members of the healthcare team.[85] The guidance finally finds that the doctor must explain the patient's condition when providing clinically assisted vital care, and explain the benefits, burdens and risks of the procedures.[86] The information must also be communicated to patients at an appropriate time, when they are sufficiently emotionally calm and not distracted by their condition, and are therefore able to understand the information conveyed.[87] To sum up, in so far as the guidance indicates, substantively, the information which patients considering withdrawal of clinically assisted vital care *must* be provided with, the following areas are clearly indicated: assessment of the patient's life expectancy and condition; benefits and burdens of life-prolonging treatments; benefits and burdens of treatments addressing the patient's experience of his condition, especially pain relief; benefits and burdens of clinically assisted vital care.

The above factors must be recorded in a patient's medical notes and communicated to the

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[84] GMC 2010 paras 14 and 24.
[85] GMC 2010 para 27.
[86] GMC 2010 paras 116, 117.
[87] GMC 2010 para 101.

patient's intimates and relevant professional parties.[88] Where patients specifically ask medical professionals about prospects of recovery, and rely on the medical expertise of their doctor, the failure of the doctor to provide a full, honest answer could be considered negligent.[89] Ultimately, however, doctors are merely able to delay a decision to refuse vital treatment/CAVC if they do not reasonably consider the patient's decision to be reasonably informed.

The legal rules governing informed consent to refusals of vital treatment/CAVC provide, at best, an indirect safeguard against incompetent suicide. A doctor remains under a duty to comply with a patient's refusal where he does not give a reason for his refusal (the basis of safeguards under the dialectically necessary framework, eg 5.3.3). If the patient does provide a reason then there is a low threshold for the doctor reasonably to judge the patient to be uninformed, and the doctor remains under a duty to comply with the patient's consent even if she does arrive at such a judgement. A possible negligence action for failure to disclose relevant information could incentivise delaying refusal. The informal guidance provided by the GMC governing 'end of life' decision-making encourages engagement with the patient's suicidal purpose to an extent, but its status as guidance obviously means that it fails to amount to a legal safeguard for competent suicide. As discussed below, the informed basis of an *advanced* decision can be decisive to the applicability and therefore enforceability of that decision (see 8.7).

8.7 Advance decisions to refuse vital treatment

8.7.1 Introduction

English law recognises that where a patient currently lacks capacity their previously expressed wishes may be treated as having a similar effect to contemporaneous refusal (MCA ss 24-26), and that a validly issued advance decision is legally binding.[90] An advance decision to refuse vital treatment must be made by an adult (18 and over) when he has

[88] GMC 2010 paras 75-77.
[89] *Pearce v United Bristol Healthcare* (1999) PIQR 53.
[90] See eg *Re AK* [2001] 1 FLR 129 at 136.

capacity[91] and could in future be subjected to anticipated treatment by, for instance, resuscitation and, at the time of the anticipated treatment, he lacks capacity to consent to it (MCA 2005 s24). The Act implicitly acknowledges the relationship between such advance refusals, unlawful killing and assisted suicide (albeit merely stating that the MCA does not alter the legal position: MCA 2005 s62). Furthermore, the situation of suicidal vital refusal was explicitly referred to in the Committee stage of the Bill (House of Commons).[92]

The directive must be clear and specific as to the treatment which is to be refused, and must acknowledge the risk to life. The courts do not adopt a formalistic approach to the legal effect of advance decisions: recent cases have found that express terms in an advanced decision may permissibly be disregarded if the overall decision conveys a contrary intention[93] or where certain formalities had not been correctly observed (rendering the decision 'invalid' under the Act).[94]

The guidelines suggest that an advance refusal of life-sustaining treatment should be discussed with a healthcare professional, who can help establish the scope of the directive (Department of Constitutional Affairs 2014, para 9.27). It is the responsibility of the patient making the advance decision to draw a doctor's attention to it (Department of Constitutional Affairs 2014, para 9.38). Furthermore, healthcare professionals following an advance directive who reasonably believe in its validity, because the evidential criteria are fulfilled, will not incur liability (s26(3)). There are two separate stages (excluding evaluation of capacity) when considering advance decisions: validity and applicability.

8.7.2 Validity

A valid advance directive must observe certain evidential requirements. A directive for refusal of vital treatment must be in writing, and must be signed and witnessed (MCA

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[91] In the case of *A Local Authority v E* [2012] EWHC 1639 (see above, 8.4) it was confirmed that as regards an advance decision to refuse vital treatment there had to be clear evidence establishing on the balance of probabilities that the decision-maker had capacity at the point of making her decision.
[92] HC Deb, cols 1380–1382, 5th April, 2005.
[93] Eg *X Primary Care Trust v XB* [2012] EWHC 1390, esp. at para 29.
[94] In a way that does not detract from the evidence of the incapacitated patient's treatment preferences *Re E* [2014] EWCOP 27.

s25(5)/(6)). In *Nottinghamshire Healthcare NHS Trust v J*,[95] the patient's advanced decision to refuse a blood transfusion did not provide evidence that the decision had been witnessed on the face of the document. However, the Court of Protection found that the failure to explicitly evidence the presence of witnesses did not detract from the validity of the directive since it was implicit from the form of the document (concurrent dated signatures) that the advanced decision had been made in the presence of witnesses.[96] This finding is within the generally purposive approach to interpretation of advance decisions adopted by the Court of Protection.

A valid advance decision is also one that has not been *subsequently withdrawn*, either expressly by the patient (or a person authorised to do so for them) or impliedly by his behaviour (s25(2)(a)-(c)). Express withdrawal is straightforward, although it does require the patient to have 'capacity' under the MCA 2005 to withdraw (see further above 8.4); therefore where a patient has a condition, such as dementia, which progressively undermines his ability to understand his original decision, he may not be able to withdraw expressly. Implied withdrawal is less straightforward and requires the doctor to evaluate the behaviour of the patient; it is therefore capable of giving rise to reasonable doubts as to the validity of the advance decision, especially as regards refusal/withdrawal of vital treatment. Section 25(2)(c) (almost certainly) requires that the patient has capacity when he acts inconsistently with the advanced directive if those acts are to be deemed sufficient to withdraw it. This is a foundational assumption of the scenarios in the guidance, and a principle which informed the approach in the common law,[97] as well as flowing from a natural reading of s25(2)(c) alongside s25(2)(a) (Pattinson 2014, 14-012).

Implied withdrawal requires the patient to act in a way that is 'inconsistent with the advanced decision'. The guidelines provide a scenario to illustrate the application of this provision: the example is given of an individual who created an advance directive to refuse vital treatment in the case of a serious debilitating accident; a number of years later such an event transpires but the individual decides initially that they wish to be treated; subsequently he loses

[95] [2014] EWHC 1136 (COP).
[96] *Ibid* [9-10].
[97] See eg *NHS Trust v T* [2004] EWHC 1279. See also MacLean 2008.

consciousness and requires life-preserving treatment in the scenario envisaged by the advanced decision (Department of Constitutional Affairs 2014, 9.40). Under the guidelines, such a person should be taken to have waived the refusal of treatment in the advanced decision. The example straightforwardly illustrates the principle of implied, rather than deliberate, alteration and waiver of a decision, and demonstrates the pragmatic nature of this requirement, recognising that people might naturally alter their settled, autonomous decisions, but do not necessarily expressly evidence this.

In *HE v Hosptial NHS Trust*, prior to the MCA 2005, the High Court refused to uphold the advance refusal of a blood transfusion by a patient. This case was similar to *Re T*, discussed above, since the patient's decision was made on the basis that such a procedure would contradict her beliefs as a Jehovah's Witness. Munby J found that the burden of proof as to the withdrawal of the advance decision to refuse vital treatment was upon the party seeking to demonstrate the validity of the decision, and that any doubt fell to be 'resolved in favour of the preservation of life'.[98] The patient's advance decision was held to have been withdrawn by her subsequent behaviour which indicated that she no longer held the beliefs that had formed the basis of her decision, because she had become engaged to a Muslim and agreed to convert to Islam.[99]

8.7.3 Applicability

The applicability of the advanced directive to refusal of vital treatment/CAVC requires a specific and clear intention that it is to apply to a given situation (s25(4)(a)-(b)); demonstrating this intention requires accurate *anticipation* by the patient of the precise scenario in which the patient wishes to refuse vital treatment (s25(4)(c)). The requirement of applicability is supported, to an extent, by the law/guidance on a 'sufficiently informed' refusal, considered above. Ambiguity in the advanced directive can be resolved by the Court of Protection but, as mentioned above, a doctor who disregarded a potentially ambiguous directive in the belief that it was invalid is unlikely to be prosecuted if he or she reasonably believed that this was the case. Section 25(4)(c) provides that when 'there are reasonable

[98] [2003] EWHC 1017 at para 46.
[99] [2003] EWHC 1017 at para 47.

grounds for believing that circumstances exist' which affect validity and applicability, re-emphasising the importance of factors 'which would have affected his decision had [the patient] anticipated them' then the advance decision may be set aside, and the doctor may take into account a wider range of factors that encompass the patient's 'best interests' which typically are not served by the withdrawal of vital treatment.

During the passage of the Bill the importance of clarity and formality in relation to advanced refusals of vital treatment were considered to constitute important safeguards against abuse (Maclean 2008, 20). Another prevalent concern was that medical techniques might improve in the interval between the advanced directive and its likely effect. The guidelines expressly consider this scenario, describing the situation of a patient who makes an advanced decision to refuse the use of a certain type of HIV medication; a number of years pass and the medication develops in ways which *might* be significant to the patient whose objection to the medication is rather ambiguous (Department for Constitutional Affairs 2014, para 9.44). The crafting of this scenario emphasises that respect for the autonomy of the patient demands that the degree of ambiguity created by the wording of the directive, and the advance in medicine, should be resolved by means intended to determine the patient's autonomous wish, but as doctors are unlikely to be liable in such cases, directives that are inherently or are rendered, ambiguous, are likely to be disregarded.

8.7.4 Conclusion and application of the PGC

The legal regulation of advanced decisions provides a legal basis for a doctor to interfere with a patient's suicidal refusal where she reasonably doubts that his suicidal purpose has been sufficiently established. In contrast to the regulation of competent suicide to establish capacity, information or voluntariness, the regulation of advanced refusals establishes a general legal framework for official oversight of suicidal purposes (eg Walker 2011, 101-102). This framework includes a prescribed form of signalling and oversight of subsequent withdrawal (validity) and assessment of the scope of the decision (applicability). Evidence that the decision is defective in terms of its informed basis or as an expression of suicidal intent are both reasons for the official to interfere with the suicidal patient's defective suicidal purpose. This amounts to a safeguard against incompetent suicide that explicitly engages with the protection of potentially incompetent agents which is the basis for Gewirthian safeguards

under a dialectically necessary framework, set out in chapter 5.

8.8 Conclusion on the "let me die" claim

The House of Lords in *Bland* confirmed the absolute status of refusal of vital treatment, regardless of the degree of medical involvement in giving effect to such a refusal when the person is competent at the point of refusal. Therefore the "let me die" claim receives far greater recognition than the other claims ("let me die," "help me die" or "end my suffering"). This form of enabled suicide is subject to such minimal safeguards that, generally, only minors or those with severe mental illnesses would be judged to be incompetent (neither category of individuals are considered in this thesis). Lord Donaldson's approach of 'risk-relativity' which favoured a nuanced judgment of competence to exercise the right to refuse vital treatment has not been adopted. This approach would have brought suicidal refusal of treatment closer to the near-absolute prohibition on assisted suicide. As Lord Goff observed in *Bland*, over two decades ago, legislation is required to rationalise the law in this area.

The development of law on suicidal *advanced* refusals, ultimately resulting in a legislative response in the MCA 2005, has not created a scheme that is not entirely premised upon an 'absolute right to refuse,' but has instead created a degree of further protection for suicidal potentially incompetent agents (PIAs). In particular, the additional formalities enable official engagement with a suicidal PIA's reason for suicide. The existence of a scheme of suicidal advanced decisions represents the most significant departure from the near-absolute prohibition on enabled suicide. The MCA 2005 scheme for advance refusal is clearly inconsistent with the argument, implicit in the government's approach to Article 8(2) in *Pretty v UK*[100] that assisted suicide creates an unmanageable risk to 'vulnerable' individuals.

As argued in the next chapter, the creation of a human rights-compliant legal framework for enabled suicide could be based on the scheme for advance refusals. However, the creation of such a scheme – and the administrative burden involved – is clearly beyond the UK's minimal responsibility to secure the generic right enabled suicide as defined in chapter 4 (see

[100] *Pretty v UK* (2002) 35 EHRR 1 para 60.

4.5.2). Therefore the inconsistency between the broad recognition for “let me die” claimants who refuse vital treatments and the other claimants is justifiable, despite the striking inconsistency of such a broad permission for only one category of claimant. This thesis is therefore in agreement with Lord Goff that legislation is needed. The proposed legislation should be based on the generic right to enabled suicide and must accommodate the *suicidal* nature of the claimant’s purpose. It is argued that the procedure should be generally available, as advance refusals currently are, without necessary interference by a court, but within extant justifiable limitations for the protection of life (an advanced incurable terminal condition creating extreme suffering, see 9.5). It is argued that suicidal advance refusals could justifiably be accommodated by such a procedure, and that this would restore, to an extent, the coherence of English law on voluntary lethal conduct.

Chapter 9: Legislative reform to give effect to the human right to enabled suicide

9.1 Introduction

English law currently provides minimal and informal oversight of enabled suicide, as this thesis has demonstrated. It relies on the DPP's guidelines, the operation of the double effect doctrine and the acceptance of refusal of treatment, discussed in the preceding three chapters. A number of legislative proposals have been put before Parliament, especially over the last ten years, that would have provided for a greater degree of recognition for the generic right to enabled suicide in English law. A momentum on the matter appears to be building up, both judicially and legislatively. The most recent proposal, the Assisted Dying Bill 2014-15, originally sought to provide a general permission for physician-assisted suicide for the terminally ill. This proposal was largely modelled on legal frameworks in other Western democracies that have legalised assisted suicide, such as Oregon. However, as discussed in chapter 6, a recent amendment to the 2014-15 Bill, tabled by Lord Pannick, radically diminished the Bill's scope (6.7.5; see further below 9.3).[1] It will be argued in this chapter that the amendment alters the nature of the legal reform represented by the Bill from a 'medical oversight model' to an 'exceptional oversight' model. Both models of reform are evaluated in terms of their potential to secure the generic right to enabled suicide in English law. The analysis will include reference to legal regimes that permit enabled suicide under such models and will refer to previous (unsuccessful) attempts to introduce such reform in England and Wales.

This chapter will firstly consider the nature of minimal legal oversight of enabled suicide under the DPP's guidelines (discussed in chapter 6) in English law combined with the domestic near-absolute legal prohibition (9.2). Switzerland is referred to as an example of a regime which adopts such a model of oversight but unaccompanied by a general legal prohibition. The Swiss example provides the context for an evaluation of current English law and of recent proposals for minimal reform focused on the DPP's guidelines. The exceptional

[1] HL Deb Vol 756 Col 1852, 7th November 2014.

judicial procedure, proposed by Lady Hale and Lord Wilson in *Nicklinson* (6.7), and now put forward by Lord Pannick as part of the new Bill, is considered as a potential remedy for the failings of the minimal oversight model as combined with a domestic legal prohibition (9.3). The chapter will then turn to the 'medical oversight' model of reform (9.4). To this end the permissive regulation of enabled suicide in Oregon and the Netherlands is evaluated by reference to the PGC. On this model, organised physician-enabled suicide is provided with limited direct and indirect official oversight by doctors in relation to limited, medically evidenced, conditions. Having derived various principles from this appraisal of the operation of such a medical oversight model the chapter will apply these to the most significant recent proposals before the Westminster Parliament, Lord Falconer's Assisted Dying Bill 2014-15, and Lord Joffe's Assisted Dying for the Terminally Ill Bill 2004 (9.5). The discussion will then lead in chapter 10 to consideration of the model preferred by this thesis, relying on the PGC.

9.2 Models of minimal oversight

9.2.1 Introduction

Law that provides for limited official oversight of the competence of suicidal potentially incompetent agents (PIAs) who seek to undergo enabled suicide may be termed a 'minimal oversight' model. In certain regimes, of which Switzerland is a notable example, assisting suicide by a variety of means, including via professional and clinical involvement, is permitted, with minimal oversight. The availability of lethal prescription is therefore not controlled by narrow safeguards, as occurs in certain 'medical oversight' regimes (eg Oregon, discussed below 9.4), but is rather a matter for the personal conscience of doctors (limited to an extent by a prohibition on encouraging suicide). It will be argued that English law currently takes a similarly disengaged stance at the moment, albeit under a legal framework that differs very significantly from the one in Switzerland. Two recent proposals put before the Westminster Parliament have contemplated minimal reforms designed to extend official oversight minimally without fundamentally altering the minimal oversight model. It will be argued, rejecting such reforms as too limited, that the minimal oversight model is fundamentally incompatible with responsible reform to secure the generic right to enabled suicide.

9.2.2 Minimal oversight in English law

English law on assisted suicide combines a general prohibition with the following permissions: *de facto* permission for intimates of a suicidal victim to enable the suicide where the victim acts voluntarily (2010 Guidelines, see 6.5); *legal* permission for doctors giving pain-relieving treatment (premised on life-shortening treatment and the double effect doctrine; see chapter 7); legal permission for a narrow category of "let me die" claimants (i.e. those refusing vital treatment/clinically assisted vital care (CAVC); see chapter 8). As regards the first category there is a lack of legal authority to govern the assessment of the suicidal potentially incompetent agent's (PIA's) competence to commit suicide. The lack of a legal judgement as to when evidence of competence is sufficient to relieve an enabler from the threat of interference has provided the basis for recent legal reforms. The legal uncertainty as to 'intimate' defendants, such as Purdy's husband (Omar Puente), resulted in the creation of the Guidelines and in subsequent revisions (after the *Nicklinson* litigation), as discussed in chapter 6. However, these reforms obviously do not address the problem of a lack of *legal* evaluation of suicidal PIAs assisted by such 'intimates'. Further minimal reforms have been proposed to the Guidelines and to s2 of the Suicide Act (see below, 9.2.4); however, it will be argued, referring to the Swiss Model of minimal oversight, that such reforms are unsatisfactory under the PGC.

9.2.3 The Swiss Model

The Swiss approach to procuring/arranging suicide by lethal medication[2] has been characterised as a *laissez faire* one (eg Griffiths *et al* 2008, 472-3), but it is not accurate to suggest that there is *no* regulation of such practices in Switzerland. Article 115 of the criminal code provides that assisting suicide for 'altruistic reasons,' and without encouragement, is not an offence;[3] of particular relevance is the prescription of narcotics used in assisted suicide by doctors, which is governed by a legal requirement that they act within

[2] In contrast to the English approach, there is no 'treatment' use of this lethal medication (Griffiths et al 2008: 472).

[3] Enabled suicide by performing the final act remains an offence (Article 114 Swiss Criminal Code).

the rules of medical practice (Zurich Administrative Court 1999; Aargau Administrative Court 2005) or risk prosecution under s86 of the Drugs Act 1996. The Swiss Federal Council has not achieved the necessary agreement to impose one decisive interpretation of medical practice with specific substantive restrictions on the prescription of lethal medication by doctors[4] but, while emphasising that the matter is centrally one of the doctor's conscience, the medical guidelines favour terminal illness as a criterion for access to enabled suicide (Griffiths et al 2008, 474) and there are also guidelines on the treatment of patients at the 'end of life' (Swiss Academy of Medical Science 2005, s1). The Federal Supreme Court issued a clarification in 2006:[5]

> ..a thorough and considered examination; a medical indication; and, with regard to the genuineness of the wish to die and capacity for discernment in this connection, monitoring over a certain period by a medical specialist…

These factors encompass protection of the vulnerable and structure the 'compassionate' provision of suicidal assistance in a way semi-analogous to the structuring of compassionate non-prosecution under the English guidelines. The result is a preference for detached, non-pressuring and strictly *assisting* involvement in suicide where the suicidal agent's reasons for suicide are genuine and are not demonstrably imprecise. However, narcotics and medical supervision are not specifically necessary for compassionate assistance, and the Dignitas organisation has introduced a helium gas injection method which obviates the need for medical oversight (Der Tagesspiegel 2008).

There is direct involvement by Swiss prosecuting authorities in ensuring that consents are valid within Swiss law, and the police/prosecutor accepts the practice of sending a visual recording of each suicide as proof that the lethal substance was not directly administered (such evidence is also valuable in satisfying the 'compassionate,' detached and non-pressuring elements of the permission for assisted suicide). In 1990 a malpractice finding resulted in the withdrawal of a license to practice from a doctor who mis-prescribed pentobarbital in circumstances where the recorded reasons for the prescription in terms of

[4] *Gross v Switzerland* (App no 67810/10) judgment of 14th May 2013 para 29.
[5] *Ibid* para 30.

diagnosis and prognosis were subsequently demonstrated to be incorrect (Griffiths 2008, 478). In another case a license was withdrawn where a doctor who was subsequently shown to have failed to perform basic checks regarding the genuineness of the patient's wish to die, or as to the capacity of the person he had prescribed pentobarbital to (Griffiths 2008, 478-79). In a similar case, in July 2013, a doctor was fined 500 Francs for failures to check the diagnosis properly` (The Local 2013a). A recent example of the risks posed by this lack of oversight in relation to informational requirements arose in the case of an Italian who travelled to Switzerland to undergo assisted suicide on the basis of a diagnosis/prognosis of terminal illness, which was revealed, upon autopsy, to be incorrect (The Local 2013b).

Prescription of lethal medication outside the condition of an identifiable 'terminal illness' or without a specified medical condition (eg rational old age suicide) is possible without prosecution, and established suicide organisations operate within the country to work with sympathetic doctors who will provide prescriptions for lethal medication to their members (for example, Dignitas and Exit). The lack of an authoritative, generally applicable, standard of medical practice defining more precisely for whom, or for what reason, assisted suicide is permitted has been criticised multiple times by the ECtHR, both as regards the potential for abuse (particularly in *Haas*)[6] and as regards the importance of requiring oversight via responsible official engagement with restrictions upon the exercise of the right in question.[7]

The primary difficulty of importing the Swiss model into English law would be that there is a lack of official engagement prior to an individual's suicide. In Switzerland the lack of guidance as regards foreign medical assessments (ie the reliance on assessments from other countries), with the concomitant difficulty of policing such information, is particularly irresponsible (such assistance is provided only by the relatively small Dignitas organisation – Exit serves only Swiss citizens). Similarly, the lack of domestic medical oversight of individuals seeking suicide other than by prescribed drugs (ostensibly for a reason stemming from a medical judgment on their condition in their own countries) is suspect. It is not only the safeguards that are lacking, however, as there are also problems created by the lack of

[6] Eg *Haas v Switzerland* (2011) 53 EHRR 33 para 57.
[7] Eg *Gross v Switzerland* (App no 67810/10) judgment of 14th May 2013 para 66; *Haas v Switzerland* (2011) 53 EHRR 33 para 69.

official support for crafting effective guidelines determining when people should be permitted to access the service. The ECtHR in *Gross v Switzerland*[8] criticised Switzerland on grounds reminiscent of the criticism of the DPP's guidelines in *Purdy v DPP*[9] in that the clarity and foreseeability of the application of rules affecting the exercise of the claimants' rights was, in both cases, deemed to be compromised (see 3.6.3). The difficulty of successfully defending specific soft law-based rules in respect of difficult cases is one which requires a *legal* response from the State, as proposed below (9.2.4). Two proposals for English reform that maintain a 'minimal oversight' model for exercise of the generic right to enabled suicide are considered.

9.2.4 Proposed alterations to the DPP's guidelines

Dame Joanne Ruddock's put a number of extremely modest proposals before the House of Commons in 2012, to request a consultation into the possibility of putting the DPP's current 2010 guidelines on a statutory footing,[10] so that alteration of the content of the guidelines by future DPPs would require Parliamentary involvement. Her proposals were put as an amendment to a motion by Richard Ottaway MP calling for Parliament to 'welcome' the guidelines – a motion which was successfully passed, but which obviously carried no official commitment. Dame Ruddock's proposals were withdrawn in the face of opposition.[11]

Placing the guidelines on a statutory footing would relate to the 'constitutional limitation' of the DPP's ability to clarify or give assurances based upon the guidelines, which was crucial to Martin's claim in the *Nicklinson* litigation (6.5.4). Parliamentary involvement would be *capable* of giving the necessary mandate to the DPP to provide guidelines. However, beyond that facially attractive possibility, the suggestion that the DPP should proceed further towards creating 'laws' on assisted suicide under the fig-leaf of s2(4) Suicide Act 1961 was rightly attacked as irresponsible, or 'back door' law-making which could not take the place of a full consultation directed towards legislation directly addressing assisted suicide (see eg David

[8] *Gross v Switzerland* (App no 67810/10) judgment of 14th May 2013 para 66.
[9] *R (Purdy) v DPP* [2009] UKHL 45.
[10] HC Deb Vol 542 Col 1357, 27th March 2012.
[11] She did not call for a vote on her amendment: HC Deb Vol 542 Col 1440, 27th March 2012.

Burrowes MP).[12] These criticisms build on the observations in 6.5 that legal reform based on creating enhanced clarity as to the prosecutorial discretion is not required by introducing the right to enabled suicide which requires a legal change. Such legal change would obviously be more effective at achieving exercise of the right to enabled suicide, more 'constitutionally appropriate', and would present more effective safeguards against depressed or pressured enabled suicide. The references to compassion and consent in the 2010 Guidelines match similar references in the Swiss law and in the Swiss Federal Court's pronouncements seeking to clarify the legal position, but in practice the onerous nature of establishing consent conditions, and the even greater challenge of addressing concerns as to informed and self-actualised decision-making, create a need for greater official engagement governed by a legal framework.

Lord Falconer's 2009 proposal went far beyond Dame Ruddock's in that it involved legislating for assisted suicide. Lord Falconer proposed an amendment to clause 49 of the Coroners and Justice Bill 2009 purporting to alter the definition of 'assisted suicide' in the Suicide Act 1961 to exclude from the ambit of the law assistance to individuals travelling to Switzerland to undergo an assisted suicide *when suffering from a terminal illness*.[13] However, the amendment was not adopted, although it did attract quite significant levels of support in the House of Lords.[14]

Lord Falconer's amendment would have provided for a degree of domestic oversight for informed decision-making in the form of requiring domestic oversight of the terminal diagnosis and the suicidal individual's capacity (both requiring independent checking by two doctors – clause 49(1)(b)), as well as a written statement by the patient that his terminal illness formed the reason for seeking suicide (clause 49(2)). These provisions would have

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[12] HC Deb Vol 542 Col 1406, 27th March 2012.

[13] HL Deb Vol 712, cols 595-634, 7th July 2009. Acts not capable of encouraging or assisting…the act is done solely or principally for the purpose of enabling or assisting T to travel to a country or territory in which assisted dying is lawful; (b) prior to the act, two registered medical practitioners, independent of each other, have certified that they are of the opinion in good faith that T is terminally ill and has the capacity to make the declaration under subsection (2)…A declaration by T is made under this subsection if the declaration- (a) is made freely in writing and is signed … (b) states that T- (i) has read or been informed of the contents of the certificates under subsection (1)(b), and (ii) has decided to travel to a country or territory falling within subsection (1)(a) for the purpose of obtaining assistance in dying, and (c) is witnessed by an independent witness chosen by T.

[14] 194 Lords opposed it; 141 supported it (HL Deb Vol 712 Col 634, 7th July 2009).

protected the vulnerable in that the patient's desire and the scope of his suicidal decision are distinctly and definitively indicated (in a written record), and the medical information (a terminal diagnosis) would have been viewed as fundamental to his generic interests as determined by the doctors involved. Furthermore, Lord Falconer's proposed criteria would have enhanced protection of the vulnerable in terms of the sufficiency of the information, since the criteria provided that recognised medical experts would have to be sought out, in light of the importance of the suicidal decision, to verify the terminal diagnosis.

The provision for medical oversight was based on the 'assisted dying' model of medical oversight of enabled suicide relied on in Oregon (9.4 below), a fact which was adverted to by Lord Joffe, who supported the proposal on that basis.[15] However, the proposal would have provided no assistance in terms of verifying the medical information related to individuals who did not have a terminal illness but who still wished to undergo enabled suicide abroad, and, similarly, would have provided no assistance to such persons seeking suicide in England and Wales (such as Nicklinson or Lamb).

Had Lord Falconer's proposed amendment been accepted then a limited exception to the offence of assisted suicide would have been created (see also 6.5). Despite certain positive elements of the proposals in tracking the requirements of the right to enabled suicide, the proposals were obviously deeply problematic in terms of giving effect to that right. The provision of clause 49(1) to the effect that assistance in suicide should be possible abroad but not domestically is absolutely contrary to the PGC and reflects one of the most problematic element of reliance on the Swiss regime – the phenomenon of 'suicide tourism' or 'death tourism', which displaces responsibility for regulation of this form of enabled suicide on to the host country (a point raised in the debate, eg by Baroness Flandaff).[16] The legalisation of travelling in order to exercise a right that is controversial or difficult to implement should not be capable of discharging a State's responsibility to engage with the right in terms of providing for its exercise or the necessary safeguards.

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[15] HL Deb Vol 712 Col 627, 7th July 2009.
[16] HL Deb Vol 712 Col 607, 7th July 2009.

Proposals of the type put forward by Lord Falconer are probably best understood as attempts at pragmatic, piecemeal change aimed at developing a movement towards introducing the right to enabled suicide in England and Wales. Lord Falconer's proposals are, however, clearly preferable to placing the DPP's guidelines on a statutory basis as Dame Ruddock proposed, since so doing would have discouraged development of legal provision for the exercise of the right to enabled suicide combined with clear safeguards for its exercise (eg Mullock 2010, 469). Also obviously her proposal would have tended to discourage Parliamentary and judicial involvement in such development, at least for a time.

9.2.5 Conclusion

It has been demonstrated above that the minimal oversight model fails to amount to responsible legal reform based on the requirements of the right to enabled suicide. The primary difficulty with this model is that there is no provision for medical expertise capable of verifying information that is material to decisions to undergo enabled suicide, which is essential to dispel reasonable doubt as to a suicidal PIA's assessment of complex factual scenarios (see also chapter 5, at 5.2.3). Furthermore, that model provides little support for checking the voluntariness of signalling, other than, arguably, addressing direct coercion.

If 'vulnerable' suicidal PIAs are to receive a level of protection in English law virtually identical to the level they currently receive under the near-absolute prohibition then reforms must provide extensive official oversight of competent suicide. Restrictions upon the availability of assisted suicide for suicidal claimants whose claims *cannot* be determined by the official procedure should therefore be maintained. Thus, if a *general* legal framework were not to be adopted then reform in England and Wales should be directed towards the creation of an *exceptional* legal procedure to achieve such oversight, which was found to be within the minimal requirement to secure the generic right to enabled suicide in chapter 6. Obviously that is not the approach advocated by this thesis, as discussed in chapter 10. This chapter will initially discuss the nature of such a procedure (below, 9.3), before evaluating the 'medical oversight' model as a model for a *general* legal framework (in 9.4).

9.3 An exceptional judicial procedure

The most recent proposal of reform came from a *judicial* source, the Supreme Court in *Nicklinson*. Lady Hale and Lord Wilson proposed that the High Court should have a role in overseeing applications for assisted suicide (as discussed in chapter 6, see 6.7).[17] Lord Neuberger was strongly in favour of Lady Hale's proposal,[18] going so far as to find that an applicant who was refused such a procedure would have a strong argument that his Article 8 right to dignified suicide would be unjustifiably infringed,[19] although Lord Neuberger ultimately denied the relevance of such an argument to the instant proceeding (see 6.7).[20]

Lord Wilson proposed a list of criteria to oversee such an application.[21] It is unnecessary to analyse his criteria in full, since relate fairly self-evidently to the framework relating to fundamental interests of the PIA set out in chapter 5. Only a brief overview of his criteria, in Gewirthian terms of generic interests, is conducted below. Lord Wilson's initial criterion, '(a),'[22] refers to capacity and voluntary choice. His subsequent criteria, (b) – (i), refer to conditions affecting the basic generic interests of the individual:

> '(b) the nature of his illness, physical incapacity or other physical condition ("the condition"); (c) the aetiology of the condition; (d) its history and the nature of the treatments administered for it; (e) the nature and extent of the care and support with which the condition requires that he be provided; (f) the nature and extent of the pain, of the suffering both physical and psychological and of the disability, which the condition causes to him and the extent to which they can be alleviated; (g) his ability to continue to tolerate them and the reasonableness or otherwise of expecting him to continue to do so; (h) the prognosis for any change in the condition; (i) his expectation of life.'

The next set of criteria (j)-(o)[23] refer to signalling and withdrawal:

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[17] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [314] per Lady Hale; [205] per Lord Wilson.
[18] *Ibid* [123-124].
[19] *Ibid.*
[20] *Ibid.*
[21] *Ibid.*
[22] *Ibid.*
[23] *Ibid*.

> ‘(j) his reasons for wishing to commit suicide; (k) the length of time for which he has wished to do so and the consistency of his wish to do so; (l) the nature and extent of his discussions with others, and of the professional advice given to him, about his proposed suicide and all other options for his future; (m) the attitude, express or implied, to his proposed suicide on the part of anyone likely to benefit, whether financially or otherwise, from his death; (n) the proposed mechanism of suicide and his proposed role in achieving it; (o) the nature of the assistance proposed to be given to him in achieving it;’

Finally criteria (p)-(r) refer to safeguards against pressured suicide:

> ‘(p) the identity of the person who proposes to give the assistance and the relationship of such person to him; (q) the motive of such person in proposing to give the assistance; and (r) any financial recompense or other benefit likely to be received by such person in return for, or in consequence of, the proposed assistance.’

These criteria unfortunately suffer from a fundamental flaw from the Gewirthian perspective advanced in this thesis, in they are not directed towards *competent rational suicide*. Instead, the criteria begin from a capacity test and move to an apparently separate analysis of the condition of the claimant. Lady Hale criticised Lord Wilson’s criteria on a similar basis, observing that they appeared to be influenced by a ‘best interests’ test, which was questionable since the procedure was being designed to cover adult persons with capacity.[24]

Lord Wilson’s criterion (g) (‘ability to continue to tolerate his suffering’) interpreted separately to his criterion (f) (medical evidence of pain and incurability) is particularly problematic in terms of the dialectically necessary framework. This is because the condition of the patient should not be regarded as constitutive of his desire to commit suicide, but is rather a guide to his reasoning process necessary to dispel reasonable doubts as to his competence (see 5.2.4 and 5.4). Lord Wilson’s approach indicates that someone with a robust

[24] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [321].

constitution who has suffered for many years, as Nicklinson had, would be *more* likely to be denied enabled suicide by a court on the basis that he would be able to continue to endure his condition. This position is contrary to the PGC in so far as it amounts to a finding that a suicidal PIA's self-esteeming and rational suicide is demonstrated to *a greater extent* by his previous struggle to continue living.

Lady Hale's proposals set forth more modest and flexible criteria that are less influenced by best interest principles than Lord Wilson's are:

> They would firstly have to have the capacity to make the decision for themselves. They would secondly have to have reached the decision freely without undue influence from any quarter. They would thirdly have had to reach it with full knowledge of their situation, the options available to them, and the consequences of their decision.[25]

Lady Hale refers to capacity but emphasises, by her first and third criterion,[26] that the crucial factor in such a test is the *internal* reasoning process of the person who is being judged. In particular, she explicitly disavows an analysis by the court as to what it is reasonable for an individual to experience in order to receive an enabled suicide,[27] which directly contradicts Wilson's criterion (g).[28] This thesis is in agreement with Lady Hale on these points.

However, Lady Hale also proposed that the procedure should be available only to those, like Nicklinson, who are 'unable' due to 'physical capacity or frailty' to put their choice into effect.[29] If, by this, it is understood that the procedure should not be available to a suicidal PIA whose signalled choice is to be assisted to die by his own action then this is counterproductive and unsupportable under the PGC. That is because there is no reason to assume that only physically incapacitated suicidal potentially incompetent agents (PIAs) have a 'good reason' to commit suicide, and there is no further distinguishing factor *in terms of*

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[25] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [321].
[26] *Ibid*.
[27] *Ibid*.
[28] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 [205].
[29] *Ibid.*

competence to distinguish this category of claimants from the other. This criterion might possibly be understood as a filtering mechanism but – while arguably indirectly defensible – such a filter is far from ideal. Its effect would be to force claimants to wait until they are sufficiently physically incapable or frail in order to qualify for enabled suicide. It is suggested that filtering criteria should instead be based upon a reasonable judgement about official capacity to hear claims and on the urgency of claims, judged by reference to the degree of the claimant's suffering and the imminence of his death.

The possibility of introducing a special judicial procedure to allow enabled suicide based mainly on Lord Wilson's criteria was discussed at the Committee Stage of the Assisted Dying Bill (2014),[30] which was conducted after the *Nicklinson* decision. The idea of a special judicial procedure received a powerful endorsement in the recent Committee Stage Debate[31] in which Lord Pannick's amendment transformed the Assisted Dying process proposed under the Bill into such a procedure. (The Bill is discussed further below, since the full legislative enactment goes beyond the scope of the minimal reform discussed in this section.) The full significance of these amendments, which are numerous and have only recently been tabled, is not yet clear, at the time of writing.[32]

It is argued that one possibility would be that the High Court could develop a special procedure for claimants under its jurisdiction within a future Assisted Dying Act, and a different procedure potentially allowing enabled suicide for those claimants who were not within such an Act. This would provide relief for applicants, such as Nicklinson, who would not fall under the Assisted Dying Bill 2014-15 as currently proposed (see below 9.5). Alternatively, it is possible that the procedure currently put forward under the Assisted Dying Bill 2014-15 will become the sole procedure, excluding such applicants. It is a further possibility, which it is argued below is unlikely, that a judicial procedure would not be 'exceptional' but would instead be made generally available under the Bill.[33] However, such

[30] HL Deb Vol 756 Col 1853, 7th November 2014.
[31] HL Deb Vol 756 Col 1853, 7th November 2014.
[32] 15th December 2014.
[33] That possibility is currently under discussion at the Committee stage HL Deb Vol 756 Col 1853, 7th November 2014.

an approach would obviously depend on a determination as to the suitability of the courts to operate such a procedure (see below 9.4.2).

The procedure is therefore deemed 'exceptional' in the sense that it is designed for the few, determined, 'Pretty-like' suicidal self-reasoners, and not because it is restricted to people with particular conditions, including physical incapacity. If such a procedure was introduced the majority of claimants would be likely to continue to rely on the DPP Guidelines since it would be so burdensome for them to rely on the judicial procedure. It is therefore argued that once a claim was able be assessed under the high quality scrutiny available in a *court* the need for limiting criteria, such as showing that an illness was terminal, would become unnecessary, in principle. It is submitted therefore that the best approach to a judicial procedure would in principle be one that is unrestricted in the sense that the limiting criteria would be minimal. However, it is obvious that that would place too great a burden on the judicial system and would mean that claims could not be heard in a timely manner.

Direct oversight by a court fails to go beyond *minimal* reform to secure the right to enabled suicide in English law. Legislation should provide an opportunity to establish a *generally available* procedure which does not require the high degree of judicial involvement in suicide anticipated by Lord Pannick's amendment. A generally available procedure is provided by the medical oversight model for enabled suicide, which is the standard model adopted in comparable Western democracies. This model is evaluated below (9.4); a final evaluation of the substantive provisions of the Assisted Dying Bill 2014-15 in light of both the 'exceptional' and 'medical' oversight models is then conducted in the subsequent section (9.5).

9.4 Models of medical oversight

9.4.1 Introduction

There are various possible approaches to legal reform directed at integrating enabled suicide and medical expertise which are compatible with the requirements of the right to enabled suicide. The aim of this thesis is not to propose ad hoc possibilities for such reform such as

those put forward by Lord Falconer. The thesis has already demonstrated that *domestic* developments anticipate regulation of certain forms of enabling suicidal decision-making (chapters 7-8). Thus the integration of enabled suicide and medical expertise is already apparent to a limited extent. In addition to these developments the common approaches in the few Western democracies that do explicitly permit enabled suicide are relevant.

The approaches to the regulation of enabled suicide in Oregon and the Netherlands in particular are representative of two alternative approaches to the integration of medical expertise and enabled suicide: the Oregon model addresses itself to terminal illness, while the Dutch model addresses itself to 'unbearable suffering' due to an incurable medical condition. The two regimes also divide over the form of enabled suicide: Oregon only permits claims to enabled suicide where the suicidal claimant can perform the lethal action himself (i.e. assisted suicide), while the Netherlands one also permits a doctor to perform the lethal act (i.e. voluntary euthanasia). The Dutch approach is flexible and provides for significant medical involvement, while the Oregon procedure is more formal, and the involvement of medical professionals is minimised. The two models are discussed below; the next section (9.5) will then proceed to evaluate proposed English legal reform, taking account of the efficacy (and failings) of these two models, and relating them to the procedure currently proposed under under the Assisted Dying Bill.

9.4.2 The Oregon Model: 'Assisted dying'

Regulatory permissions for enabled suicide where an individual is dying and has made an explicit, formal,[34] voluntary and informed request with capacity have been recognised in Australia and by a number of States in the US.[35] Oregon's particular and more permissive model was clearly premised on seeking to give effect to patient autonomy (see eg Jackson 2012, 9; Huxtable 2007, 10). This model of regulation retains a limitation based on the performance of the final, killing, act by the person seeking suicide, so killing by request is an

[34] Oregon Legislation ch 127.810: the request must be written, signed, dated and witnessed.
[35] For example: Australia Northern Territory Rights of the Terminally Ill Act 1995 (overturned in 1997); USA Oregon Death with Dignity Act 1997; USA State of Washington Death with Dignity Act 2008; USA Vermont End of Life Choices Act 2013; Montana The Rights of the Terminally Ill Act 1991 interpreted in accordance with the decision in *Baxter v Montana* (2009) MT 449.

offence (murder).[36] The requirement that the enabler abstains from participation in the 'final act' is broadly defensible on the basis that the involvement of the enabling agent presents less opportunity for interference with the consenting agent's will, and presents greater opportunity for State monitoring of the nature of consent after the suicidal agent has signalled it (see 5.4.2).

The limitation under this model confining valid claims to those based on being in the final stages of a 'terminal illness'[37] elevates the oversight of *this type* of information to decisive importance. It is necessary, if this narrow limitation is to be justified, to demonstrate that terminal illness, as opposed to, for instance, physical incapacity, is particularly susceptible to effective oversight in terms of evidencing competent suicide. The primary strength of the 'terminal illness' criterion was found in chapter 5 to rest on its susceptibility to scrutiny, in contrast to the difficulty of evaluating the availability of alternative medical treatments, and other alternatives courses of action to remedy the suicidal potentially incompetent agent's (PIA's) suffering condition (see 5.4.6). The possibilities created by a vast range of medical treatments presents a very broad relevant informational field which patients, and indeed even medical experts, would struggle to appreciate fully in terms of its significance.

There is clear evidence to suggest that terminal illness is a common reason for enabled suicide. Terminal illness is the most common reason for requests for euthanasia and assisted suicide, even in jurisdictions that permit enabled suicide for other reasons (such as in the Netherlands and Benelux countries where over 80% of requests are from terminal stage cancer patients (Lewis and Black 2012)). The Oregon legislation requires that a claimant must be suffering from a terminal illness. But so long as that is the case, it does not require that the illness forms the basis for his request. The condition is treated, rather, as an initial filtering requirement for the claimant to access the legislative scheme. In this respect the Oregon legislation is not entirely consistent with a reason-based approach to terminal illness as a safeguard limiting the generic right to enabled suicide. It is important to emphasise that

[36] The suicidal individual must be able to make a hand movement (eg lifting a cup to his/her mouth and swallowing).
[37] The diagnosis of 'dying' under the Oregon model requires a relevant medical specialist to confirm that the patient is suffering from an 'incurable and irreversible' disease that is, within reasonable medical judgement, result in death within 6 months (ch. 127.800(12)).

the relevance of 'terminal illness' to the exercise of the right to enabled suicide is not a quality of life assessment. As argued in chapter 2, a quality of life assessment can be objected to on the basis that it could be insensitive to a suicidal PIA's own assessment of his experience of terminal illness (see 2.5.2; see also eg Keown 2012, 131). The significance of terminal illness as providing evidence for a valid exercise of the right to enabled suicide is entirely based on the agent's own reason for suicide and on the accuracy of the medical oversight of that reason.

The accuracy of the terminal diagnosis is, of course, crucial and the Oregon model provides for the independent checking of the diagnosis and independent oversight mechanisms designed to regulate enabled suicide.[38] There is no evidence that fatal misdiagnoses have occurred in Oregon although, naturally, there are cases of people who were deemed eligible for enabled suicide on the basis of a terminal prognosis, who lived far beyond that prognosis. However, the regulatory framework is itself criticised for providing limited support for oversight and identification of malpractice by medical institutions (Gorsuch 2009, 118-119). Furthermore, the strict application of medical confidentiality interferes with reporting (eg Keown 2012, 132*f*). There is some evidence that individuals have been prescribed lethal medication on the basis of a diagnosis of 6 months life expectancy, but who have in fact lived for over three years (Living and Dying Well 2011; Oregon State Health Reports 2011). This evidence agrees with the generally attested to difficulty of formulating an exact life expectancy prognosis for patients with various forms of terminal illness due to the broad range of variables involved in making such estimates (eg Gorsuch 2004, 1375 *et seq*).

Once the initial filtering stage has been passed in Oregon, the request to die must be found, by a doctor, to be informed.[39] That includes the requirement that the doctor must provide information material to the decision to undergo enabled suicide in terms of alternative treatments to the patient so that he can, if he wishes to, consider them. One problem is that effective scrutiny of such provision of information is more difficult to achieve than creating checks on the diagnosis of terminal illness (eg Halliday 2013, 159-60). But on a reason-based model of medical oversight, as supported by the dialectically necessary framework, it is

[38] Oregon Legislature ch 127.815, 127.820.
[39] Oregon Legislature ch 127.830.

inconsistent to rely on diagnosis alone. Therefore, as chapter 5 argued, provision must be put in place to ensure that such scrutiny is effective (5.2.3). A further failing of the Oregon legislation is that it does not provide that advice on palliative care alternatives (Keown 2012, 130; Halliday 2013, 159-60), must be given by a doctor expert in such care (although the Oregon Department of Public Health has confirmed that a high percentage of patients are enrolled in hospice care (ODPH 2014)). Such advice should be given because an uninformed agent could reasonably regard his condition to be one of 'extreme suffering' (a term that conveys a condition which undermines one's basic generic interests, see 5.2.3) because he was unaware of alternatives to treatment which could readily have been provided to him.

In terms of safeguards that investigate reasoning behaviour, the Oregon model provides that the decision must be freely made with an inbuilt delay for reflection.[40] This safeguard is reported to be uncontroversial in practice. Safeguards against depressed suicide are apparent: the Oregon model prohibits lethal prescription where there is evidence that the patient's decision suffers from impaired judgement due to the influence of psychological disorder and depression.[41] Where there is evidence that the patient suffers from impaired judgment the Oregon model provides that he may be referred for counselling.[42] The assessment of relevant factors goes beyond the narrow capacity evaluation in English law under the MCA to include psychological factors and *depression*. This is a broad category that could potentially operate to delay/exclude a great number of people with terminal illness, given the flexibility of 'depression' as a psychological disorder (eg WHO 1991). The framework in 5.2 provides a PGC-compatible basis for justifying interference with the right to enabled suicide created by such a broad competence assessment (see 5.2.5). But despite the breadth of the assessment criterion the rate of referral for psychological assessment is reported to be low (eg Oregon Health Authority 2013), providing the basis for criticisms that this requirement is not being applied strictly (Keown 2012, 133-135; Haliday 2013, 159), although the evidence is disputed (Jackson 2012, 64).

[40] A written and oral request for the lethal prescription must be reiterated after 15 days and a further 48 hours left before the request is complied with (Oregon Legislature ch 127.840).
[41] Oregon Legislature ch. 127.800(3), 127.825(3).
[42] Eg Oregon Legislature ch. 127.825.

It is important to emphasise that the term ‘depression’ used in psychological parlance, and evaluated solely from a clinical perspective, does not adequately convey what is meant by a safeguard against depressed suicide under the dialectically necessary framework, which establishes that depression refers to an agent’s dispositional/occurent disregard for his generic interests (see 5.2.3 and 5.2.4). The suicidal agent’s reason for enabled suicide and the way in which this is weighed against his generic interests is therefore a crucial element in an official’s assessment of ‘depression’. But that element is not apparent in the Oregon scheme. Psychological evaluation of the competence of an agent can give expert insight into factors relevant to the agent’s mental function and emotional condition (both dispositional/occurent), but such an evaluation cannot fully capture depression as a condition that contradicts an agent’s ‘competence’ in terms of the exercise of the generic right to enabled suicide. The relevant conception of ‘depression’ adopted under the dialectically necessary framework in chapter 5 was as a ‘self-disregarding’ state (see 5.6.3).

There are two key failings of the Oregon regime in terms of its capacity to conduct official evaluations of a ‘self-disregarding’ conception of depression: firstly, the prescribing physician does not necessarily know the patient before she conducts her assessment of the patient’s mental/psychological impairment; secondly, the practice of referrals is not reviewed from a non-clinical perspective such as by way of an ethical review panel (Halliday 2013, 162). The first issue, of a close relationship, was found to be relevant to the way that an agent official (in Oregon, the doctor who reviews the applicant) assesses the ability of the suicidal potentially incompetent agent (the patient) to weigh his condition against the continuation of his agency (see 5.2.3). The importance of an established *personal* treatment relationship for effective informed consent is well established in other contexts (eg Maclean 2009, 72*ff*.), and the lack of such a relationship in the Oregon scheme is deemed a crucial failing in light of the particular emphasis on review of patient competence in the Oregon legislation.

The Oregon model has been criticised as ‘all too conscientious’ by opponents of permissive reform (eg Gorsuch 2009, 115), by which is meant that there is an excessive focus on the appearance of formality and safeguards, which in practice lack content. It is criticised in particular for the lack of oversight or support for the patient’s decision-making at the point at which the suicide occurs; this means that the actual suicidal action could be the product of impaired judgment despite the provisions of the Act (Gorsuch 2009, 179). It is argued,

contrary to these criticisms, that the minimal degree of assistance in suicide provided for in the Oregon legislation, which leaves the final act of suicide to the individual, does not require the degree of oversight that is provided for in models, such as the Netherlands' one, where the involvement of medical professions is significant (see 5.4.2). Therefore the minimal assessment of competence under the Oregon scheme as a safeguard against depressed suicide is defensible under the PGC.

9.4.3 The Dutch model: the requirement of unbearable suffering

Under the Dutch model voluntary euthanasia and assisted suicide is available to patients with capacity[43] who are experiencing 'unbearable suffering' due to a medical condition. The scheme is governed by the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (2002 Law).[44] In contrast to the Oregon 'assisted dying' law the Dutch scheme provides for the significant involvement of an enabler in the final act of suicide, including the performance of the final act itself. The requirement of 'unbearable suffering' under the 2002 law has been clarified by the Regional Review Committee (RRC): it is a requirement that the patient has judged the medical condition as one that is 'unbearable' from *his* 'perspective, personality, and relevant norms and values' (2002, 23). The basis for the law is the 'due care' requirement placed on Dutch medical professionals (Article 293, 294 Penal Code). There has historically been a particular emphasis in Dutch healthcare on autonomy and self-determination, and the importance of positive support for such self-determination is strongly emphasised in Dutch law (Griffiths et al 2008, 13*ff*.; Kimsma and van Leeuwen 1993, 29-30).

The various 'slippery slope' objections to the Dutch model rest in essence on the criticism that it is excessively flexible (Huxtable 2007, 19*ff*.). In particular, examples are given of euthanasia which lack written signalling of the patient's request (Keown 2002, 115-24). A recurrent argument of this nature has been advanced in various forms since the legalisation of forms of enabled suicide on the basis of 'necessity' in the Dutch Supreme Court case of *Schoonheim* (1984; Keown 1994; Twycross 1995), which led to the 2002 Act. This criticism

[43] RRC 2001, 17. In cases of doubt about capacity a psychiatric consultation is required (KNMG 2003, 13).
[44] Article 239 Dutch Penal Code.

is often applied to the situation of a doctor or family member who assumes that evidence of unbearable suffering alongside suicidal behaviour amounts to consent to euthanasia (Keown 2012, 135). Initially, the Remmelink Report recorded killings of patients capable of expressing their request, but where there was no evidence of such a request, but merely evidence of the doctors' assessment of unbearable suffering and incurable disease (Remmelink Report 1991; Keown 2012, 118-120). These criticisms are obviously valid under PGC.

The 2002 Act does not specify that there must be the legal formality of a written request, but the RRC have found that an evidenced request is usually necessary to demonstrate voluntariness (RRC 2005, 15). The Dutch model has therefore responded to criticisms that an impression of implied consent was given by the relatively less regulated Dutch approach in the 1990s, and as a result more formal and individually focused evidence of consent and of unbearable suffering has been adopted (Griffiths et al 2008, 77*ff.*). The progression towards firmer evidential requirements for individual consent runs contrary to a crude 'slippery slope' argument that legalisation of euthanasia and assisted suicide ultimately results in unwanted killing of 'vulnerable' patients (Jackson 2012, 55-60).

In contrast to Oregon's 'assisted dying' model, the Dutch approach to evidence of a medical condition is necessarily linked to a suicidal PIA's *reason* for suicide. The Dutch interpretation of the criterion of unbearable suffering is similar to the 'extreme suffering' criterion defended under the framework in chapter 5 (5.2.3, 5.2.4). The fact of 'unbearable suffering' must be understandable to doctors and to the review committees, meaning that the suicidal patient's reasons for desiring suicide are subject to evaluation (Griffiths et al 2008, 116). The suffering must also have no 'prospect of improvement' (i.e. be non-relievable), a requirement that treatment alternatives that could possibly 'cure' the patient of the condition complained of have been exhausted (2002 Law Ch II A.1b). This further limitation is also a directly justifiable safeguard under the dialectically necessary framework on the basis that medical evidence of a condition cannot demonstrate 'extreme suffering' unless readily available and non-burdensome alternative treatments have been explored (see 5.4.5). This is because there must be evidence that the suicidal PIA has weighed his condition against the continuation of his agency: he cannot demonstrate that he has done so using medical grounds

if a treatment that would cure his condition and remove its effects upon his basic generic interests has not been considered.

Exceptional cases of 'unbearable suffering' beyond the paradigm type of intolerable pain have been recognised (eg RRC 2006, 23). Recent, controversial, examples of such interpretations include those of a Dutch woman who was considered to be suffering unbearably due to loss of sight (Dutch News 2013); she was also undergoing unbearable emotional suffering caused not directly by a complained of incurable medical condition, but instead by the disruption to her life (eg to relationships, independence etc) created by being placed in care (eg Netherlands Times 2014). Anticipation of suffering can be *factored into* an assessment of current unbearable suffering, since it forms part of the patient's feeling that the situation is 'hopeless' (RRC 2006, 23). These developments have been characterised as approaching a 'humane death' interpretation of unbearable suffering (Griffiths *et al* 2008, 142) which tracks the right to enabled suicide in the sense that control over the dying process, rather than the presence of particular types of distressing symptoms, is the basis of this requirement.

The expansion of conditions of 'unbearable suffering' to include medically evidenced conditions going beyond the pain associated with dying (which is associated with the sanctity of life doctrine, see eg 7.2 and 8.2) is within the framework of safeguards based on requiring a 'good reason' for suicide under the PGC. This is because 'extreme suffering,' interpreted in accordance with the dialectically necessary framework set out in chapter 5, encompasses conditions that undermine an agent's basic generic interests and which are not solely affected by the impact of pain and dying (see 5.2.3-5.2.4). However, the nature of 'emotional suffering' as an evidenced condition falling within the requirement of extreme suffering complicates the assessment of 'depressed suicide' under such a framework, as discussed below. Briefly, that is because emotional suffering necessarily detracts from the suicidal PIA's *rational* weighing of his condition against the continuation of his agency (see also 5.6.3). Thus, while the expansion of conditions is not, it is argued, a 'slippery slope' in the crude sense of necessarily leading to an irresponsible oversight of the exercise of the right to enabled suicide, the inclusion of such conditions can be brought within a 'slippery slope' argument based on a tendency towards official tolerance of 'depressed' suicide (eg Keown

2012, 121). As argued in chapter 5, the potential for such a slippery slope is not a conclusive argument against departure from a near-absolute prohibition of enabled suicide (see 5.6.2).

The requirement of providing and checking medical information relevant to the expansive criterion of the 'no prospect of improvement' criterion places a far more onerous obligation on Dutch physicians to satisfy the 'due care' criteria than is placed on physicians in Oregon. An extensive survey of the relevant medical information must be undertaken, which is then independently checked by a relevant expert (2002 Law Ch II A.1e), and provision is then made for further checking until the attending physician is satisfied to a sufficient extent that the specified condition is non-relievable. In relation to difficult cases of unbearable suffering and incurable disease the attending physician is supported by the availability of consultation with the Regional Review Committees (2002 Law Ch III Art.3). The challenge of satisfying the onerous informational requirement under an 'unbearable suffering' model of medical oversight of enabled suicide provides the foundation for various 'slippery slope' objections to the effect that the non-relievability criterion is not always proven to the level apparently required by 'due care' (Keown 2012, 150-52). However, there is no indication that the criterion of non-relievability of suffering has been progressively interpreted in an expansive way that permits involuntary killing (eg Griffiths et al 2008, 91).[45]

In terms of *considered* suicidal purpose the Dutch healthcare ethic is broadly commended for supporting patient self-determination (Kimsma and van Leeuwen 1993; Halliday 2013, 147*ff.*). Supportive medical decision-making was assumed to be part of the Dutch law to the extent that a physician who was not in an enduring relationship of treatment with a patient (i.e. not a relationship based upon enabling the patient's suicidal purpose) was, shortly after the law's passing, necessarily deemed to act without due care (RRC 2002, 18). However, subsequently, a more nuanced approach was adopted: the prior treatment relationship is now required only in so far as necessary to meet the informational duties under the 2002 Act. The current approach includes a requirement that the doctor has established that the patient has adopted a considered approach to his diagnosis/prognosis and to the treatment information of which he must be informed (2002 Law Ch II Art 1b.; RRC 200, 22). The patient must also

[45] Controversial examples have included disorientation caused by dementia and anxiety/upset created by other forms of mental disorder (RRC 2011, 13).

understand and consistently communicate his decision over a long period, implying an extended period of consultation between himself and his doctor (2002 Law Ch II Art 2; Griffiths *et al* 2008, 306-09;).[46]

Doctors are advised to seek a psychiatric assessment of patients whose choice to undergo enabled suicide might be the result of depression (KNMG 2003, 15; 2004, 39). Objections to the capacity of doctors to identify depression accurately and screen for it can be raised against the Dutch model, similar to those that can be raised against the Oregon model (Keown 2012, 119). It was argued under the framework of safeguards put forward in chapter 5 that generic indicators of self-esteem could not be established beyond crude suggestions of emotionally influenced decision-making (eg insomnia, weight loss, use of anti-depressants; see eg Halliday 2013, 153; see 5.6). However, the Dutch model is superior in certain respects to the Oregon one. Unlike the Oregon model, the emphasis on an established relationship and review by the committees provides further opportunities for assessment of depression that go beyond identifying an obvious emotional disorder, and extend to an assessment of the patient's rational self-esteeming reason for suicide (RRC 2006; Griffiths *et al* 2008, 129*ff*.). The close engagement between the physician and the suicidal patient is credited with creating the capacity to identify forms of subtle depression and pressure/influence associated with the self-abnegating suicidal intent of terminally ill patients (Jackson 2012, 48-49). The Oregon model is criticised on the basis of the minimal level of referrals to psychologists it reveals, but such criticisms cannot be made with the same force against the Dutch model (Halliday 2013, 147*ff*.). The review committees evidence extensive reporting of requests where there is evidence of familial pressure, especially when associated with 'depressivity' (RRC 2003, 16; see also Griffiths et al 2008, 87).

9.4.4 Conclusion on the Oregon and Dutch models

The oversight of the medical conditions provides the essential basis for the operation of the two regimes in Holland and Oregon. Under the dialectically necessary framework proposed in chapter 5, the medical condition must be interpreted in terms of providing a 'good reason'

[46] See also RRC 2006.

for suicide, as opposed to relying on an assessment of the best interests of the terminally ill (see 5.2.3). Furthermore, clinical and non-clinical evidence pertinent to the remediability of the complained of condition is a fundamental aspect of the evidence relating to that condition. The Dutch model adopts a position that is more consistent with a justifiable limitation on the right to enabled suicide, since evidence of a condition of unbearable suffering that is irremediable must be evidenced if a doctor is to satisfy her duty of care to the patient.

In the Netherlands the existence of failures to observe strict formalities as regards an evidenced request for enabled suicide has been criticised as a fundamental rejection of safeguards against incompetent and even involuntary euthanasia (Keown 2012, 135). The extent to which such criticisms remain valid is disputable after the inception of the 2002 Act, but it is clear that the Oregon model, which is explicitly *premised* on such formalities is not susceptible to such criticism (Jackson 2012, 64-65). That might appear to indicate that the safeguards under the Oregon model would necessarily be superior to those within the Dutch model in terms of evidencing competent suicide. Evidence of advance signalling of enabled suicide is a straightforwardly justifiable limitation under the PGC (see 5.4.2) and to this extent the flexibility of the Dutch regime may be criticised. However, the reliance on such formalities does not address the problem of safeguards against depressed suicide.

The Dutch model is more firmly premised upon an established decision-making relationship between the doctor and patient on the basis that a doctor owes a particularly extensive duty of care to her patient, which in many respects encourages an engagement with his decision-making process. The Dutch model of autonomous medical decision-making is closer to what, in the framework in chapter 5 was termed ‘self-esteeming’ suicide (i.e. not ‘depressed’ suicide). The Oregon framework, meanwhile, despite formal referral requirements, has gravitated to a position that is closer to the nature of the ‘absolute’ right to refuse treatment in English law (discussed in chapter 8) in which the doctor accepts that her patient’s reasons for dying are his own and that she is not involved in his decision-making process. The implication of the Oregon approach is that as long as the applicant has a terminal prognosis then there is only a limited basis on which a doctor can become involved in the decision, and the fact that she is excluded from the final act of suicide further establishes the Oregon model as one of distant engagement. This approach is closer to the Swiss model of minimal engagement in assisted suicide, which was considered above (see 9.2.2).

It will be argued below and in chapter 10 that English reform proposals that seek to implement the Article 8 right to *enabled suicide* (i.e the generic right to enabled suicide: see 2.6, 4.4) should be guided by the *Dutch* approach to an extent, rather than the Oregon model. The Oregon model does, however, in many respects represent a more achievable short-term realisation of a generally available procedure for enabled suicide in the absence of a Dutch model for medical decision-making in the UK. The defects in such an approach should be addressed in order to establish the strongest basis for safeguards against competent suicide that will withstand future challenge and 'slippery slope' criticisms.

9.5 Proposals for initial legislative reform to implement the medical oversight model in England and Wales

9.5.1 Introduction

The Oregon model provides the foundation for the two most significant recent proposals of legislative reform mentioned above: the Assisted Dying Bill 2014-15 (2014-15 Bill) and the Assisted Dying for the Terminally Ill Bill 2004 (2004 Bill). The 2014-15 Bill essentially requires the terminally ill suicidal claimant to make an advance decision which, once deemed valid on the basis of various criteria, means that a doctor is able to lawfully assist (clauses 1-3). However, there are a number of departures from the Oregon model in the Bill: they include, in particular, Lord Pannick's amendment to require judicial oversight of all claims (9.5.2), and a provision, included in the original Bill, to require oversight of the *use* of the suicidal 'device' (9.5.3). The implications of these proposed departures are considered in detail below, as is the retention of a standard 'assisted dying' framework to limit the scheme to the 'terminally ill' (9.5.4), the provision of information about alternative treatments (9.5.5), and the creation of safeguards against depression and pressure (9.5.6).

9.5.2 Judicial procedure

It had been anticipated that the Assisted Dying Bill 2014-15 (2014-15 Bill) would follow a procedure that was not dissimilar to the one which exists in Oregon. The original Clause 1 of the 2014-15 Bill read as follows:

> A person who is terminally ill may request and lawfully be provided with assistance to end his or her own life.

Clause 1 of the 2004 Bill adopted similar terminology.[47] However, this crucial clause was immediately amended in the Committee stage of the Bill. Lord Pannick's amendment proposed a procedure by which a person could lawfully be provided with assistance subject to the consent of the High Court.[48]

It was suggested above that Lord Pannick's amendment amounted to a transformation of the proposed scheme from one based on a generally available 'medical oversight' model to one premised on an 'exceptional procedure' (see 9.3). The procedure currently proposed is exceptional in the sense that only a limited amount of claimants who could possibly fulfil the criteria put forward would be able to benefit from it. The basis for arguing that a necessary component of judicial review of competence would limit the category of claimants is that few claimants would have the time and resources to petition the High Court. Another sense in which the procedure would be exceptional is that if the judicial procedure were to be *effective* then it would cover only a narrow range of (evidently self-esteeming) claimants. It will be argued that effective judicial scrutiny would be intrusive and disruptive to claimants who were not obviously competent.

It is clear that the impact on a claimant's time/resources created by pursuing a *judicial* evaluation of competence would be far greater than the impact of receiving a medical evaluation, as occurs under the Oregon/Netherlands models, simply by virtue of the need to engage a number of legal professionals. However, there are of course various means by which time/cost could be minimised. Lady Butler-Sloss, a past President of the Family Division,[49] drew attention to the speed and efficiency with which the Family Court could decide cases. Lord Ribero confirmed her remarks, referring to cases of blood transfusion which require particular urgency (see also determinations on the capacity for patients to

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[47] Subject to the provisions of this Act, it shall be lawful for— (a) a physician to assist a patient who is a qualifying patient to die… (Assisted Dying for the Terminally Ill Bill 2004).
[48] HL Deb Vol 756 Col 1852, 7th November 2014.
[49] 1999-2005.

refuse vital treatment in chapter 8, at 8.4.3).[50] Similar reassurances were made in relation to the costing of such a procedure. In particular, Lord Faulks (Minister of State, Ministry of Justice) indicated that legal aid could be made available.[51]

However, there is a paradox in relying on the High Court while trying to restrain time/costs, since a rushed and under-resourced judgment would risk becoming a 'rubber stamp' which would undermine the reasons for relying on a court procedure in the first place. The paradox deepens if the assessment of capacity were to be broadened to include depression, as under the Oregon/Netherlands regimes. The current Bill does not include such a clause and refers merely to 'capacity' (clause 3(3)), a term which Lord Falconer has made clear should not be interpreted as going beyond the current legal definition.[52] However, a number of their Lordships have proposed amendments to include an enhanced burden of proof generally,[53] an enhanced capacity assessment,[54] and certain amendments that explicitly reference depression as an aspect of such an assessment.[55] It was argued in chapter 5 that a court is an ideal forum within which a high degree of scrutiny needed to assess capacity can be brought to bear, which is why a court could provide exceptional oversight of competence to commit suicide (see 5.3.2). However, it is implausible to suggest that the High Court can conduct such scrutiny without a significant additional commitment of time/resources.

Lady Butler-Sloss, in particular, in the Committee, emphasised the ability of a court to conduct a flexible and rigorous assessment of a competent suicide; she gave the example of her own assessment in the significant *Re B*[56] case (see 8.2). The case involved a suicidal claimant who sought a declaration that it would be unlawful to continue to ventilate her (see 8.2.2). Ms B's competence was demonstrated exhaustively by three separate psychological evaluations which provided extensive evidence of her mental state, but such evidence was not relied on in isolation. Lady Butler-Sloss also questioned Ms B in detail about her suicidal

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[50] HL Deb Vol 756 Col 1865, 7th November 2014.
[51] HL Deb Vol 756 Cols 1879-80, 7th November 2014.
[52] HL Deb Vol 756 Cols 1904, 7th November 2014.
[53] Amendment 64 by Lord Carlile, Lord Darzi and Lord Harries.
[54] See eg Amendment 77 by Lord Bishop of Bristol and Baroness Nicholson of Winterbourn and Amendment 92 by Lord Alton of Liverpool.
[55] See Amendment 66, advanced by Lady Butler-Sloss and Viscount Colville of Culross and Amendment 71 advanced by Baroness Hollins.
[56] *Re B* [2002] EWHC 429.

purpose and was, in her terms, convinced over three days of the court hearing that Ms B was competent to end her life.[57] Ms B's decision to pursue withdrawal was made in September 2001 and the High Court delivered its judgment in late March 2002 (the hearing dates were in early March).

The *Re B* case is illustrative of the capacity of the High Court to produce a rigorous judgment that can establish a suicidal PIA's competence to commit rational suicide, but it also indicates that the High Court can achieve such a standard only if a full case is presented to it to dispel reasonable doubts as to competence. This is not what has occurred in all cases of suicidal refusal of vital treatment under the current capacity test. For example, in *Newcastle Upon Tyne Hospitals Foundation Trust v LM*[58] the hearing (by video-link) occurred over a single day, involved no expert psychiatric evaluation contemporaneous to the patient's refusal of treatment and no evidence (psychiatric or otherwise) of absence of depression other than historical conjecture.[59] Jackson J was able to hear the case on the *day* on which the application was made by the hospital trust, such was the time pressure. It is not suggested that the judicial procedure in the 2014-15 Bill would be conducted in such emergency circumstances, but the difference in the quality of the judgement when compared to that in *Re B* does serve to illustrate the paradox of placing strict time/resource constraints on judging competence.

The second objection to Lord Pannick's amendment is that a court procedure would either amount to an official intrusion into a process of suicidal self-reasoning, if it was rigorous, or would fail to engage with that reasoning, and thus be minimally effective to evaluate competence, if it was not. This problem was not discussed explicitly by their Lordships in the Committee Stage of the 2014-15 Bill. However, this objection lies behind many criticisms of the Bill itself. For example, in the second Reading of the Bill[60] Lord Condon commented upon the difficulty of setting a balance between 'intrusive insensitivity' and 'indifferent complacency' (referring to investigation of subtle pressure applied by family members). The effect of such 'intrusive insensitivity' was discussed in relation to the dialectically necessary

[57] *Re B* [2002] EWHC 429 [53].
[58] [2014] WL 1220013.
[59] *Ibid.*
[60] HL Deb Vol 755 Col 863, 18th July 2014.

framework in terms of the counterproductive burden placed on a suicidal PIA by official intrusion into his process of self-reasoning in order to judge it (see argument as regards official 'proximity' to an agent's purpose in 5.2.3). The combined administrative and personal burden of an intensive judicial procedure would be considerable, particularly for individuals who are not as obviously self-esteeming as were Tony Nicklinson, Diane Pretty or Debbie Purdy. Statistics in Oregon and Netherlands differ as to the levels of *clinical* depression exhibited by claimants, but they agree that a significant percentage of applicants are recorded to have signs of depression (eg Ganzini 2008; Griffiths 2008, 87*ff*.). It is self-evident that the emotional and physical strain of dying and suffering tends to undermine competence. However, if the High Court were to adopt the current, generally limited, capacity assessment for suicidal refusals of treatment (as in the *LM*[61] case above) then this would border on an 'indifferent complacency'. This would mean that the court hearing could be characterised merely as an expensive rubber stamp.

It is contrary to the distinctive nature of a court, as an institution capable of subjecting a suicidal PIA's competence to intensive scrutiny, for it to adopt a restrained approach. It is argued that a medical context for such oversight is clearly more capable of providing a restrained review of the suicidal purposes of patients, but it is necessary to demonstrate that such a setting would not be complacent about conducting such an assessment. The medical oversight model is, of course, not free from the criticism that such evaluations could become 'complacent' (eg Oregon above, 9.4.2), but there is no reason to find that a court procedure would not be susceptible to similar criticism. The primary distinction between the Oregon and Netherlands regimes described above arose on the basis that in Oregon the suicidal procedure is treated as a medical exception and overseen by scrupulous formality. However, the comparison did not favour Oregon. Rather, it is the approach in the Netherlands that is generally considered to be the more effective, due to the inclusion of the suicidal procedure within a developed medical relationship.

This thesis is in agreement with Lord Falconer's statement that there is no ideal solution to preventing clinical or judicial complacency about competence assessments if a restrained

[61] *Newcastle Upon Tyne Hospitals Foundation Trust v LM* [2014] WL 1220013.

approach is adopted.[62] However, it is suggested that clinicians who are *guided by the court and by legislative safeguards* should be capable of assessing competence. Doctors are already legally entrusted to arrive at clinical judgements about suicidal or 'life-shortening' treatments, as discussed in chapters 7 and 8. Furthermore, doctors are obviously trusted to make decisions about a patient's basic competence to choose to refuse procedures that are manifestly beneficial to a patient's basic generic interests (such as amputation for a diabetic.

To conclude, Lord Pannick's amendment[63] was put forward as a direct response to *Nicklinson*[64] but, for the reasons given in this section and above (see 9.3), the alteration of the Assisted Dying Bill 2014-15 to a judicial model was not an appropriate way to obtain *exceptional* relief for claimants in that case, or in general. As discussed above and in chapter 6, the Bill's *scope* renders it inappropriate as a means of offering exceptional relief from the near-absolute prohibition on assisted suicide for claimants who are suffering but not dying. It was established in chapter 6 (see 6.7) and above (see 9.3) that a judicial Assisted Dying procedure would do nothing to remedy the violation of the generic right to enabled suicide of the relevant applicants in *Nicklinson* (i.e. Tony Nicklinson and Paul Lamb). It has been argued in this section that necessary judicial oversight would also do little for dying applicants, at least when compared to a 'medical oversight' framework.

9.5.3 Degree of assistance and oversight

The safeguards against depressed suicide provided for in the Bill, discussed below (9.5.6), must be related to the degree of assistance provided. In the case of the Assisted Dying Bill 2014-15 the degree of assistance is potentially very extensive, although neither Lord Joffe's Assisted Dying for the Terminally Ill Bill (2004 Bill) and the 2014-15 Bill extend to the exercise of enabled suicide by voluntary euthanasia. In contrast to the Oregon model considered above (see 9.4.2), the regime anticipated by the 2014-15 Bill includes providing for significant involvement by an enabler in setting up a 'suicidal device' (the same applied under the 2004 Bill). In particular, it would allow a doctor to enable self-administration

[62] HL Deb Vol 756 Cols 1932-1933, 7th November 2014.
[63] HL Deb Vol 756 Cols 1854, 7th November 2014.
[64] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200. See 6.7.

which amounts to the setting up of a 'suicide machine'. Clause 1(a)(ii) of the 2004 Bill would have provided that:

> in the case of a patient for whom it is impossible or inappropriate orally to ingest [the lethal] medication [the doctor shall assist the patient to die by] prescribing and providing such means of self-administration of that medication as will enable the patient to end his own life…

This is echoed in Clause 4(4) of the 2014-15 Bill:

> (4) In respect of a medicine which has been prescribed for a person under subsection (1), an assisting health professional may— (a) prepare that medicine for self-administration by that person; (b) prepare a medical device which will enable that person to self-administer the medicine; and (c) assist that person to ingest or otherwise self-administer the medicine; but the decision to self-administer the medicine and the final act of doing so must be taken by the person for whom the medicine has been prescribed.

The above proposed clauses approach the degree of medical assistance rendered in the Dutch model.

The 2014-15 Bill in its current form denies *absolute* control to the suicidal individual over the suicidal 'device' (the drug as well as the means of self-administration). In particular, the suicidal claimants would be unable to store the drug in their homes before the point at which they intend to commit suicide (clauses 4(6) and 4(8)).[65] The healthcare professional involved must remain physically present during the process of self-administration of the drug, but not necessarily in the same room (clause 4(6)). The provision for maintaining a degree of clinical control over the suicidal 'device' in both Bills was based on the perceived problem that

[65] Clause 4(6): 'The assisting health professional must remain with the person until the person has— (a) self-administered the medicine and died; or (b) decided not to self-administer the medicine.' Clause 4(8): '…an assisting health professional—must only deliver any medicine prescribed under this section to the person for whom they have been prescribed immediately before their intended use; and (b) in the event that the person decides not to self-administer the medicine, must immediately remove it from that person and, as soon as reasonably practicable, return it to the pharmacy from which it was dispensed.'

safeguards against incompetent suicide would be rendered ineffective if there was a substantial delay between the authorisation and the suicidal act (see also 9.4.2). This provision does, however, mean that the individual who is undergoing such a procedure must endure the presence of a healthcare professional at the time in question, despite being capable of administering the lethal drug himself. The clause also increases the potential for subtle official and clinical pressures that could undermine safeguards against depressed suicide (see below, 9.5.6).

9.5.4 Terminal illness

The 2014-15 Bill only covers those diagnosed with terminal illnesses - its most fundamental feature. A condition that can be medically measured is, of course, an essential feature of a scheme based on demonstrating terminal illness or unbearable suffering, and therefore independent checking of diagnoses, as in Oregon and the Netherlands, was anticipated by the 2004 Bill (clause 3(c)) and 2014 bill (clause 2(1); clause 3(3)). It was argued above, as regards the Oregon assisted dying model, that its approach to terminal illness operated as an eligibility condition which the suicidal applicant/patient must fulfil rather than as contributing to his *reason* for suicide. That approach was criticised on the basis that it could not be directly supported by the PGC (see 9.4.2). The same criticism applies to the 2014-15 Bill.

The Commission gave its reason for adopting an assisted dying model based on a diagnosis of terminal illness as follows (Commission on Assisted Dying 2011, 27):

> The intention of the Commission in recommending that any future legislation should permit assisted suicide exclusively for those who are terminally ill and specifically excluding disabled people (unless they are terminally ill) is to establish a clear delineation between the application of assisted suicide for people who are terminally ill and others with long-term conditions or impairments. The adoption of this distinction in any future legislation would send a clear message that disabled people's lives are valued equally.

This reasoning straightforwardly accepts a principle of the equal value of life of the disabled/able-bodied which would be supported under the sanctity of life or inviolability of agency positions (see further 2.4-2.5).

Keown, whose theory of the sanctity of life is referred to in this thesis, has attacked the creation of distinctions between terminally ill patients and non-terminal patients under the 2014-15 Bill. Specifically, he criticises the implication that terminally ill patients are 'better off dead' (2012, 170-72; 2014, 1). In other words, Keown finds that a scheme should not be predicated on attributing varying values to the lives of those who might seek enabled suicide. This thesis agrees, but not on the basis of the sanctity of life doctrine. As discussed above, and throughout the thesis, under the PGC the patient's condition of suffering, in the sense of not wishing to be burdened by his life any longer, is of importance as providing an evidenced reason for his decision. Clearly, that criterion under the PGC does not distinguish between the value of life of disabled persons as compared to that of those who are terminally ill. It also accepts that able-bodied persons would not necessarily be excluded from enabled suicide due to the application of that criterion (5.2.3). To elaborate upon the crucial significance of the distinction between the stance under the PGC and that taken by those theoreticians (and by the members of the Committee on the Bill) who rely on attributing value to certain lives as an eligibility criterion for enabled suicide, it is useful to embark on a reminder as to the distinctions between categories of patient that *are* potentially justifiable under the framework in chapter 5.

1. If enabled suicide is justified because competent patient (S) thinks that *he* is "better off dead" because he is terminally ill then, since he possesses the generic rights, he has a right to require official (O) not to interfere with his suicide. However, if O cannot evaluate S's competence (eg has made no attempt to judge S's decision) then, from O's perspective, S's apparent 'request' for enabled suicide could in reality be a 'request' for involuntary killing which S is not entitled to make.
2. If O, as an agent who possesses a dialectically necessary insight into S's view, makes a (valid) attempt to judge S's expressed view that he is "better off dead" due to terminal illness then O will find that S's purpose requires him to make a uniquely difficult judgement about his generic interests, which is also uniquely harmful to S; O is therefore justified in holding S to a high standard of competence and interfering

with S's decision if she is not satisfied that he achieves that standard. In order to judge S's decision:

a. if O can establish a close relationship with S because it is not too administratively burdensome then she can judge his competence directly (i.e. an exceptional procedure);
b. if the administrative burden of establishing a close relationship between O and S is too great then she cannot judge his competence directly. She is therefore in a difficult position if she is to uphold S's generic rights: if she refuses to judge S entirely then she might violate S's generic right to enabled suicide, but if she judges S precipitately then she might violate S's generic right to life by failing to interfere with his involuntary killing. Her attempt to judge must *differentiate between the different reasons* that S could proffer as the basis for his suicide without incurring too great an administrative burden. A terminally ill patient seeking enabled suicide would inevitable refer to his terminal illness as one of the reasons, but under the PGC that reason could only operate as a potentially compelling basis for the suicide. Where S proffers that reason O must be able to find that S is able to weigh it against the continuation of his agency. The fact that he is burdened by the knowledge that his illness is terminal (and in some instances by physical suffering associated with the illness, which may be increasing) may undermine his appreciation of his basic generic interests. Thus, as discussed in chapter 5, under the PGC, extreme suffering, which may be due to terminal illness but need not be, is relied on as the eligibility criterion for enabled suicide. As also discussed, in order to diminish the administrative burden on persons in O's position it is necessary for the condition in question to be *reliably evidenced* (i.e. be an incurable medical condition: 5.2.3).

It follows from the discussion above that from O's perspective, she has attempted to establish that S's 'request' was genuinely one of enabled suicide and not involuntary killing (see chapter 5 generally, 5.2-5.4). But it is argued below that the use of terminal illness as the sole eligibility criterion is less effective in ensuring that O can make that distinction. It is also clear that, contrary to Keown's view, models of medical oversight that rely on unbearable suffering can be interpreted in a way that does necessarily imply a quality of life judgement

contrary to the inherent equality and dignity of human beings, as understood under the PGC (Keown 2012, 122-23; see 9.4.3). However, the assisted dying model captured in the current Bill is clearly more problematic in this regard: as indicated, its reliance on judgements about quality of life do not demonstrate an effective correlation with ensuring that O does not fail to intervene in involuntary killing.

Lord Joffe's Assisted Dying for the Terminally Ill Bill 2004 (2004 Bill), unlike the 2014-15 Bill, would have provided for the exercise of the right to enabled suicide limited to *both* terminal illness and extreme suffering.[66] The Commission on Assisted Dying, which provided the basis for the 2014-15 Bill, defended this change as follows (2011, 305):

> …a criterion based on suffering would be too unclear and subjective for doctors to assess… it would be inappropriate for such a system to rely on one person making a judgement about another person's quality of life…We firmly believe it is only for the individual concerned to judge the extent of the suffering caused by their illness.

The Commission had assumed that there was validity in adopting a safeguard in the form of an eligibility criterion and, on that basis, preferred terminal illness as a more neutral (objective), clear and limiting criterion. The adoption of an assisted dying eligibility criterion can be justified only indirectly under the PGC (on the basis of relieving the administrative burden on O). The reliance on such a criterion based on terminal illness also affects the operation of safeguards against depressed/pressured suicide, as discussed below (see 9.5.6).

This thesis finds that the retention of irremediable extreme suffering as an eligibility criterion, in addition to that of terminal illness, is *supportive* of human dignity, contrary to the stance of the current Commission since as discussed above and in chapter 5 its focus is on the patient's reasons for wishing to die. Halliday, in criticising the Oregon model that forms the basis for the Commission's proposals, and in defending the 2004 Bill, calls for a 'more European

[66] The Bill would have provided that a physician could enable suicide by prescribing lethal medication (Clause 1(a)) only if the patient had been determined to have a terminal illness (Clause 2 (c)) and was 'suffering unbearably as a result of that terminal illness' (Clause 2 (d)).

approach' to the unbearable suffering criterion in terms that reflect the interpretation of that criterion under the right to enabled suicide defended in this thesis (2013, 151) finds:

> The Assisted Dying Bill [2014-15] should be amended to permit assistance in cases where the patient is suffering unbearably without prospect of improvement; by its very nature the subjectivity of the unbearable suffering requirement complements the promotion of dignity, without increasing the scope for abuse.

9.5.5 Availability of alternative treatments?

Under the dialectical framework put forward in chapter 5, it was essential that information as to the availability of alternative courses of action to suicide should be made available to the PIA since such information could be relevant to the evidence proffered of extreme suffering. It is contrary to the PGC to accept terminal illness as a good reason to commit suicide if there is no evidence that other viable options have been explored. The lack of a requirement of reference of a patient to palliative care *experts* in Oregon was criticised above in this regard, and the 2014-15 bill currently also suffers from this failing (clause 4(4));[67] Halliday 2013: 159-60).[68] It is argued that the failure to regard the availability of alternatives as crucial within the legislative framework of the Bill, which is a prevalent criticism of reform allowing enabled suicide, is the result of the preference for use of terminal illness as an eligibility criterion rather than as an aspect of evidenced reason for suicide.

9.5.6 Safeguards against pressure and depression

Oversight of the voluntary basis upon which the decision is reached (Clause 3(3)(c)), and the evaluation of the capacity of the suicidal claimant (Clause 3(3)(b)) are the primary safeguards

[67] The 2014-15 Bill provides that the Secretary of State may issue a code of practice in relation to the provision of information on treatment options/palliative care to patients (clause 8(1)(iii)).
[68] Lord Cavendish, Lord Mackay and Baroness Grey Thomson's amendments also seek to address this point. Eg Amendments, 164 and 170. HL Deb Vol 756 Col 1945, 7th November 2014.

against pressured suicide proposed in the Bill. The operation of safeguards to prevent pressuring actions capable of overbearing the will of a robust suicidal claimant (see 8.5) is not seen as problematic in either the Oregon or Dutch regimes. However, the deficiency of the proposed safeguards in relation to depression and to the *intersection* between depression and subtle influences is an extremely prevalent criticism of the current proposals in the Bill and of all proposals to legalise enabled suicide (Keown 2012, 170*ff*.). The proposed safeguards against depressed suicide are minimal, since the 2014-15 Bill relies solely on 'capacity' under the current legal definition (discussed further in 8.4), which has limited application to subtle factors of dispositional incompetence, such as depression.

Lord Falconer indicated at the Committee stage that he would take into consideration the insertion of a clause on capacity that included reference to a medical assessment of depression similar to that in the Oregon model.[69] A great number of amendments addressed capacity; the amendment to which he ultimately gave qualified approval was that of Lady Butler-Sloss:

> Unless the attending doctor [and a judge] is satisfied that a person requesting assistance to end his or her own life has the capacity to make such a decision and is not suffering from any condition, including but not limited to depression, which might be impairing his or her judgement, the attending doctor shall refer the person making the request to a psychiatrist for a specialist assessment of that person's capacity.[70]

Unlike the alternatives,[71] this amendment did not require psychiatric evaluation as a necessity, and did not require a judicial analysis of depression reaching beyond consideration of the capacity of the claimant to make a decision. This amendment was the most extensive

[69] HL Deb Vol 756 Col 1933, 7th November 2014.
[70] HL Deb Vol 756 Col 1933, 7th November 2014.
[71] Eg Amendment 65 tabled by Lord Carlile Lord Darzi Lord Hariies.

capacity assessment that Lord Falconer was prepared to accept. He defended his preference by reference to the judicial procedure.[72]

Lord Falconer therefore did not support Lord Carlile's tabled amendment (Amendment 65) which is as follows:

> For the purposes of this Act, an applicant has capacity commensurate with a decision to end his or her own life and a clear, settled, informed and voluntary intention to do so if he or she-— (a) is not suffering from any impairment of, or disturbance in, the functioning of the mind or brain or from any condition which might cloud or impair his or her judgement… (c) has maintained over a reasonable period of time a firm and unchanging intention to end his or her life; (d) is not the subject of influence by, or a sense of obligation or duty to, others.

Lord Falconer argued that this amendment would go beyond the current capacity test, since such a clause would allow rejection of a clear decision to die. Lord Falconer challenged Lord Carlile's amendment on the basis that it could exclude a person who was depressed but would still have capacity to convey a clear decision to undergo enabled suicide:

> …suppose someone is depressed because they are going to die imminently but the doctors and the judge are satisfied that, although the person is depressed, which might be an appropriate response to what is happening, they are absolutely clear that that is what they want to do…[73]

The approach adopted by Lord Falconer is therefore similar to the approach in Oregon in that evidence of depression under that scheme does not necessarily provide a basis for rejecting claimants (see eg Halliday 2013, 153). The implication is that so long as the applicant has a

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[72] '…a judge will consider this issue. He or she will consider not just whether the right process has been gone through but will have to be satisfied—it is a primary question of fact for the judge—that the person applying to get the prescription has the capacity to make the decision, so you have that final safeguard. If the judge is not satisfied or thinks that a psychiatrist should be involved, there is the protection…' HL Deb Vol 756 Col 1933, 7th November 2014.

[73] HL Deb Vol 756 Cols 1933-1934, 7th November 2014.

clear and settled desire to undergo enabled suicide and is not psychotic he is unlikely to be refused under the current Bill. The fact that a suicidal applicant has a demonstrable terminal illness would tend not to encourage officials to undertake a close evaluation of the patient's mental state. However, unlike the position under the Oregon model, the degree of assistance under the 2014-15 Bill is non-minimal. As discussed above (9.5.3) the Assisted Dying Bill provisions require a clinical involvement with the suicidal applicant that approaches the level of involvement in the Netherlands, although it does not amount to the direct administration of the suicidal 'device' (i.e. a lethal injection). The combination of official involvement and a narrow capacity test has been extensively criticised for permitting *passive* suicide to a greater extent than under either the Dutch/Oregon models (eg Keown 2006, 129; 2012, 169). Passive suicide is a disengaged and self-disregarding suicidal purpose. It will be argued below that the problem of passive suicide is a general problem arising under the assisted dying model captured in the Bill as a model of medical oversight.

The problem of passive depressed suicide and the intersection with influence may be effectively illustrated by a hypothetical scenario. The following hypothetical scenario is partly based Keown's (he refers to a depressed suicidal patient 'Ethel'; 2012, 169) and references the case of Nathan Verhelst (discussed in 5.6.2),[74] but is intended only to illustrate the problem of passive suicide under a narrow capacity test in the current Bill. The hypothetical suicidal applicant in this scenario is 'Nathan'. Nathan is an 85 year old transsexual man (before gender reassignment he was known as Nancy) who has recently been diagnosed with terminal cancer and given a prognosis of 6 months to live. He falls into a serious depression on receiving this diagnosis and becomes suicidal. He is not on speaking terms with most of his family but he does have a cousin, Roger, with whom he has maintained contact. As the sole member of his family with whom he is still in contact Nathan has recognised Roger as beneficiary to his substantial estate.

After the diagnosis Nathan contacts Roger and expresses his wish to die. Nathan reveals that he wants an assisted death mainly because of his (irrational) fear that the drugs used in the late stages of his palliative care might cause him to act in a feminine way while semi-

[74] It also refers to a fictional story-line in a popular soap opera in 2013-2014 (BBC 2013b).

conscious. Roger agrees that this would be an undignified death and suggests that he use the 'Falconer procedure' (i.e. the procedure under the 2014-15 Bill, which in this scenario has become law). Nathan does not approach his own doctor whom he considers would not approve him for such a procedure and instead finds a clinical practice that advertises that it will conduct the necessarily referrals for the 'Falconer procedure'. The doctors at the clinic briefly assess Nathan and judge him to be 'understandably depressed' by his terminal condition but not in a way that indicates that he needs psychological assessment, since he is not suffering from delusions and has a clear and settled purpose. On this basis they advise him to contact a solicitor to arrange for a formal declaration and an application to the High Court (in order to access the 'exceptional judicial procedure' available under the Bill).

At this point, before Nathan has applied to the Court, Nathan's only daughter, moved by her father's decision, decides to make amends with her father before he dies. Due to her action Nathan begins to doubt whether he should go through with the process and once more consults Roger. Roger, seeing the daughter as a rival for Nathan's inheritance, is adamant that Nathan's original decision was the correct one. He reminds Nathan that if he draws out his death "Nancy would return" referring to Nathan's fear that he will behave as though he is still Nancy under the influence of end-stage drugs. This influences Nathan and he applies to the Court. The judge reviews the official declaration prepared by the solicitors and the doctor's notes which find that Nathan has capacity, and on this basis, as well as on the basis of a brief interview with Nathan, she decides that his case is a straightforward one and grants the necessary approval. On the day of the procedure Nathan has serious doubts but feels that the situation is hopeless and that he cannot discuss his fears with the healthcare professional assigned to his case partly because he has never met her previously. After a short wait in which he is mindful of the presence of the professional and feels humiliated and unsure Nathan ultimately decides that he 'might as well go now rather than later' and takes the lethal medication.

The above scenario is illustrative of three aspects of passive depressed suicide which, it is argued, reveal deficiencies in safeguards proposed in the Bill. They also devalue Nathan's agency in a way that is contrary to the PGC. Firstly, Nathan satisfies the terminal illness criterion; the fact that his reasoning process is self-abnegating and distorted is not revealed by clinical/judicial questioning as to *why* his terminal illness is a reason for his suicide (see also

as regards Oregon model, 9.4.2), as it would be under a PGC-based scheme (see 10.4.2). Secondly, the capacity assessment is narrow and not designed to find that the fact of depression would undermine Nathan's dispositional competence to choose to commit suicide; so there is no justification for delaying or interfering with Nathan's apparent choice. Finally, there is no relationship between Nathan and the healthcare professional or the legal officials, and they do not need to engage with his self-reasoning in order to advance the procedure once a declaration has been declared valid. The lack of a relationship means that there is limited engagement by the healthcare professional/officials at the crucial points of signalling and overseeing suicide (see also discussion above as regards the Dutch model, see 9.4.3).

9.5.7 Conclusion

The Oregon legislation was criticised above for being 'all too conscientious' in form while lacking in substantive safeguards (Gorsuch 2004, 1370; 9.4.2) and it has been argued that the 2014-15 Bill suffers from similar defects. The proposed formal safeguard of securing the involvement of the High Court in *all* applications for the procedure is a safeguard that goes far beyond those available in Oregon or the Netherlands. However, the actual efficacy of such involvement is unclear, since the judging process in the High Court would necessarily be subject to constraint. The process would suffer from the same failings that undermine oversight by medical professionals in Oregon: under an assisted dying model claimants who meet the eligibility criteria are strongly presumed to have the right to commit suicide, and therefore officials apply safeguards in a restrained fashion, since the main safeguard predates the judging process.

Safeguards against depressed suicide (which were found to pose problems in terms of their efficacy and were therefore viewed as the strongest basis for a prohibition on enabled suicide under the PGC in chapter 5 (see 5.6), are undeveloped under the 2014-15 Bill. Since the 2014-15 Bill is based on an Oregon-style model it would create a scheme that was relatively ineffective in terms of providing safeguards against depressed suicide when compared to the Dutch model. The explicit adherence under the Bill to the current minimal safeguards based on capacity against depressed suicide, which are applicable to "let me die" claimants, is unfortunate, since the current capacity test sets a low standard for evaluating such claims. The problem is even more acute given that a significant proportion of terminally ill claimants are

likely to suffer from depression.[75] However, safeguards that would apply in *English* law obviously could not rely on the medical culture that exists in the Netherlands which, due to its informal nature, would risk involuntary killing if applied in this country, so safeguards against depressed suicide appropriate to the English institutional context must be advanced. The next chapter will offer a PGC-based proposal of reform which would be appropriate to that context and would also avoid the failings of the Oregon model (see 10.4).

9.6 Conclusion

Reform of the current English model of minimal oversight and near-absolute prohibition is clearly needed in order to address its intrusive, arbitrary and ineffective application, which is contrary to the generic right to enabled suicide. Two key models of reform have been examined above: minimal reform as contemplated in *Nicklinson*[76] based on an exceptional procedure by which to judge all claimants who have the resources, time and robustness to undergo direct examination of their suicidal purpose; non-minimal reform based on the Oregon or Netherlands model, which includes a general legal framework to permit enabled suicide within safeguards primarily overseen by the medical profession.

The primary difficulty with the medical oversight scheme is that it fails to strike a balance between formal safeguards and effective engagement with suicidal patients. The relatively established Dutch regime, which permits voluntary euthanasia only for individuals who are suffering unbearably, is preferred in this thesis on the basis that its safeguards are clearly based on a close engagement between the doctor and the patient's reason for suicide. The 2014-15 Bill, however, reflects the Oregon regime of 'assisted dying' which does not develop the law sufficiently beyond the minimal oversight framework. The legal safeguards in the Bill are extensive but are subject to formal restraint, and therefore fail to engage with the challenges of fully evaluating a claimant's competence to undergo enabled suicide. The next chapter will conclude the evaluation of English law under the generic right to enabled suicide and propose a reform that is directed towards a proportionate restriction upon its exercise.

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[75] Select Committee on the Assisted Dying for the Terminally Ill Bill (2005) HL-Paper 86 II para 244.
[76] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200. See above 9.3.

Chapter 10: Conclusion

10.1 Introduction

As this thesis has shown, especially in chapters 6 and 9, a momentum is building up in England and Wales, judicially and legislatively, towards the introduction of a right to enabled suicide. But as those chapters demonstrated, in various respects the developments currently under contemplation create arbitrary distinctions between those seeking enabled suicide that are indefensible under a direct application of the PGC. The thesis has also sought to demonstrate that the existence of the near-absolute prohibition on assisted suicide, combined with very limited 'exceptions' (chapters 6, 7 and 8), fails to create effective safeguards against involuntary killing that are PGC-compatible. This chapter will indicate the direction that legislative reform that was PGC-compatible could take. In so doing it will rely heavily on the discussion of the right to enabled suicide under the PGC in chapter 4, the safeguards set out in chapter 5, and on the evaluation of the Oregon and Dutch models in chapter 9, which have currently found some realisation in the Assisted Dying Bill 2014-15. This chapter is not intended to set out a full legislative framework that could answer to the demands of the PGC, as discussed in particular in chapter 4. But it will delineate the key features of such a framework (10.4.2) and will use the example of Nathan, considered in chapter 9 in relation to the provisions of the Assisted Dying Bill 2014-15, to illustrate the way it could operate in practice (10.4.2).

10.2 The Convention right to enabled suicide

The development of a right to enabled suicide under the ECHR after *Pretty v UK*[1] has so far had a limited impact on English law. Its impact has only been on 'soft' law as represented by the DPP Guidelines. The *Purdy*[2] and now *Nicklinson*[3] decisions based on the Convention right to enabled suicide have been accompanied by judicial calls for legislation addressing voluntary euthanasia and assisted suicide. These calls for reform refer to the need to respect the human rights of those competent suicidal people, particularly the physically disabled, who

[1] *Pretty v UK* (2002) 35 EHRR 1 para 65.
[2] *R (Purdy) v DPP* [2009] UKHL 45.
[3] *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200.

are currently prevented from dying on *their terms* by the English near-absolute prohibition on assisted suicide and voluntary euthanasia. However, is *Pretty* itself part of the problem? The confused 'narrative' of the ECtHR in both recognising a right to enabled suicide under Article 8 but simultaneously approving of the 'sanctity of life principle'[4] under Article 2, and denying that the Convention right to life includes its own 'negative'[5] has, it has been argued in chapter 3, undermined the ECHR as an instrument of human rights-based legal reform.

This thesis has sought to justify the Article 8 right to enabled suicide as a generic right of agency (chapter 4). The UK's responsibility to enact law to uphold such a right derives from its duty to uphold the right to life as an 'agent right' to control the continuation of life. The UK's responsibility to uphold this absolute right is based on the intrinsic value possessed by all agents, on the basis of their agency, which is comparable, to a limited extent, to the theorised sanctity of life position on the Article 2 right to life considered in this thesis (that of Keown, see 2.4). Both the inviolability of agency and sanctity of life positions can justify limits upon the UK's responsibility to uphold this right to life 'absolutely' so that the UK government is not implausibly required to preserve the vital signs of human agents indefinitely under its jurisdiction after they are no longer capable of agency ('vitalism,' see 7.2). Both positions can also justify the UK government's interference with enabled suicide so that the government is not implausibly required to ignore suicides which could amount to involuntary killing (the crude 'slippery slope' argument, see 5.5-5.6). However, of course, beyond this minimal degree of agreement, the two positions diverge because the PGC defends *control* over the generic conditions of agency as a (dialectically necessarily) intrinsic good while the theorised sanctity of life position defends *continuation of agency* as an intrinsic good (see 2.4-2.6).

The ECtHR's most significant finding in *Pretty* was that a near-absolute prohibition on assisted suicide combined with restrained prosecution of that offence might be defensible. The basis for this finding was stated to be the threat created by a more permissive regime to the 'vulnerable,' which would include other persons whose condition (i.e. of terminal disease and anticipated suffering) caused them to be suicidal, like Pretty, but who were at greater risk

[4] *Pretty v UK* (2002) 35 EHRR 1 para 65.
[5] *Pretty v UK* (2002) 35 EHRR 1 para 39.

than she was of incompetent suicide (i.e depressed or pressured suicide).[6] However, the conception of protection of the 'vulnerable' was undeveloped. It was therefore necessary in this thesis (chapter 5) to consider and defend an interpretation of a necessary and proportionate restriction upon the Convention right to enabled suicide under the PGC. The basis for that analysis arose from the criterion of necessity for action under the PGC which establishes that an agent's freedom (to authorise another to assist his suicide) and his well-being are similarly fundamental to his ability to act and therefore are of equivalent weight under the PGC.

The necessary and proportionate restrictions on the generic right to enabled suicide were established by reference to a principled framework based on the PGC (in chapter 5). The premise of this framework was the need for protection of a suicidal potentially incompetent agent (S) by an official (O) who could interfere with the person enabling his suicide (E) if she found S's signalled desire to commit suicide to be deficient. The framework justified the existence of fundamental procedural safeguards to prevent O arriving at a mistaken judgement as to S's desire to undergo enabled suicide. The content of these safeguards was found to be sensitive to the nature of E's enabling conduct and to the extent to which S's reason for suicide could be evidenced to O. The framework also justified the existence of fundamental substantive safeguards to minimise the risk of a mistaken judgement that S's suicide was free from pressure and depression.

10.3 The application of the generic right to English law

The compatibility of English law with the generic right to enabled suicide in relation to the "take my life" and "help me die" claimants was found to be undermined by the impact of the sanctity of life principle (see chapter 6). In general, an action of intentional killing or assisting in such a lethal action is prohibited regardless of the victim's authorisation of or control over the lethal action. English law on enabled suicide is therefore *prima facie* incompatible with the PGC and compatible with the sanctity of life principle. However, despite the obvious difference in basis between the PGC and that principle, the necessity of

[6] *Pretty v UK* (2002) 35 EHRR 1 para 74.

safeguards to prevent conduct directed towards killing evidently incompetent suicidal agents means that a near-absolute prohibition on enabled suicide is potentially defensible. As discussed in chapter 5, the justifiability of safeguards against incompetent suicide means that in the absence of a general framework to oversee competence a near-absolute prohibition on assisted suicide is justifiable. The justifiability of safeguards against depression provides the strongest argument for safeguards that restrict all claims to enabled suicide, since those who have a 'good reason' to commit suicide are also those whose competence is under the most stress (see 5.2.4-5.2.5). Nevertheless, the absence of even an exceptional procedure to permit enabled suicide clearly amounts to a violation of the generic right to enabled suicide of "help me die" and "take my life" claimants.

It is argued that prosecutorial behaviour in England and Wales is illustrative of the over-broad nature of the law against assisted suicide. Prosecution is rare for certain categories of suspect where the suicidal 'victim' is competent, the suspect is an intimate of the 'victim' and the suspect's actions are 'compassionate' (see 6.5). The public interest in prosecuting assisted suicide has, as the DPP Guidelines have now made clear, shifted towards an inviolability of agency view that a competent suicidal agent can authorise assistance in his suicide. Nevertheless, the UK's responsibility to enact *legal* permissions for enabled suicide is the subject of this thesis and the DPP's policy fails to represent a moral judgement in favour of even the exceptional permissibility of such suicide. The DPP's published guidance merely enables a suicidal 'victim' to inform a person who assists him as to the general likelihood of prosecution. The ECtHR erred in so far as it can be taken to have found in *Pretty* that prosecutorial restraint should be understood to lessen the UK's responsibility to arrive at a human rights-compliant legal judgement on assisted suicide (see 3.6.2).

The legal permission for certain "end my suffering" claims in English law is compatible with the theorised sanctity of life position (see 7.2). 'Life-shortening' treatments and withdrawals of treatments are permissible on the basis of the principle of double effect (8.2). The moral import of double effect is not supported by the PGC which justifies moral responsibility for actions based on volition (7.2, 7.4). However, certain of the other legal restrictions upon the exercise of the "end my suffering claim" are defensible, such as the necessity of a clinical setting and of evidence that the claimant was suffering and dying. The arbitrariness of law governing life-shortening treatment is most apparent where a patient who is dying as a result

of a suicidal refusal of treatment requests life-shortening treatment. The advantage of such treatment in that situation is obvious, but where the patient is clearly suicidal and the doctor enters into that purposes it is not clear that the doctor would not act with the primary intention of ending the patient's life, which is impermissible (7.3.3). The legal position is uncertain as to whether such an act would be permissible (7.3).

The legal permission for "let me die" claims is anomalous given the general adherence to the sanctity of life principle and the prohibition on assisted suicide. The application of the action/omissions distinction to withdrawal of vital treatment in *Bland*[7] is rejected by both the PGC and the theorised sanctity of life position, since both positions would find the doctor to be morally responsible for the death of a patient upon withdrawal of vital treatment. However, under the PGC the doctor's acquiescence in such withdrawal with the consent of the patient is, of course, justifiable in order to give effect to the patient's generic right to enabled suicide (8.2). The 'legal fiction' of omissions in this context is characterised by an explicit denial that doctors are responsible for this form of lethal conduct. This denial has resulted in a dramatic inconsistency in the legal protection of this form of suicidal claimant in English law.

The limited safeguards against incompetent refusal of vital treatment means that the permission for "let me die" claims operates in a particularly arbitrary fashion. The safeguards are so limited that they would not generally interfere with a "let me die" claim since their narrow application could not plausibly be judged to extend beyond evaluating the decision of a minimally competent (ostensible) agent. The only instance in which safeguards might interfere with the "let me die" claim arises when the claimant adopts a form of signalling that is based on a future contingency (advance refusal). The restrictions governing such advance refusals include various formal safeguards for suicidal signalling that comply with the fundamental PGC-compliant criteria set out for the formal assessment of signalling in 5.4. It is therefore strikingly inconsistent with the near-absolute prohibition on assisted suicide that safeguards designed to minimise the risk of depression and pressure are judged to be legally sufficient in the situation of withdrawal of vital treatment, but not in relation to minimal acts

[7] *Airedale NHS Trust v Bland* [1993] AC 789.

of assisted suicide such as prescribing lethal medication. This legal judgement therefore further undermines the notion that the near-absolute prohibition is rationally defensible under the PGC.

10.4 Legal reform based on the PGC

10.4.1 Minimal legislative reform

It is argued that minimal, immediate, reform should not abandon a general near-absolute prohibition on assisted suicide without a legislative framework of safeguards in place. What is required is an exceptional legal procedure that provides for direct official involvement in enabled suicide so as to provide a safeguard for suicidal PIAs in England and Wales. The current lack of such a procedure is a violation of the generic right to enabled suicide of "take my life" and "help me die" claimants. It was argued in chapter 5 that it was necessarily the case that an official judgement about the competence of suicidal PIAs can be arrived at if there is direct official involvement. The fact that such involvement is burdensome and counterproductive, inserting an alien element into what is the most intimate and significant final moments of a person's life, is, for some, such as Tony Nicklinson, a price that they must accept for bringing an unwanted existence to a close on their terms (see 9.3). Such a procedure would be slow, costly and limited only to certain determined applicants, but it would meet their need.

The inconsistencies in the legal approach to lethal conduct in the medical sphere require reform to avoid inconsistent judgements that discriminate between similar suicidal claimants. If the various legal judgements are to be defensible under an ethically rational Gewirthian approach it is necessary to alter the narrow, confusing and disempowering limits on enabled suicide without extending its scope so that the current, limited, safeguards for suicidal PIAs are eroded. It is argued that this is achievable by minimal reform so that claimants should receive enabled suicide who are: dying; have a short time to live; are experiencing extreme suffering due to the dying process which cannot be managed by pain relief. The signalling procedure should be based on that which is currently used for advanced decisions, except that it should not be limited to refusing vital treatment, but should extend to 'actions' of lethal treatment and should seek to preserve the patient's control over the final lethal act where

reasonably possible. Finally, doctors involved in such a procedure should not act in such a way as to create reasonable doubts about their good faith in supporting the suicidal purpose of the claimant, so their action should be directed primarily towards relieving his suffering. None of these requirements are alien to the current indirect safeguards provided by current law on medical involvement in lethal conduct (7.4).

This proposed reform is extremely modest, especially in view of its limitation to a patient who is expected to die imminently where his suffering cannot be managed by pain-relief. This limitation is defensible because such a claimant can necessarily evidence his good reason to commit suicide, since he is suffering extremely and, due to the imminence of his death, it is clear that nothing more can be done for him. This exception would have provided relief, for example, to Annie Lindsell (who suffered from motor neurone disease; see further 7.3). Lindsell applied to the high court just two weeks before she died in order to ascertain clearly whether her physician could lawfully relieve her extreme emotional suffering due to her fear of dying by suffocation (BBC 2000). A narrow permission for physician assisted suicide as a rationalisation of the current law on voluntary lethal treatment decisions would enable a narrow category of claimants in the "end my suffering" situation to achieve their suicidal purpose.

10.4.2 Initial legislative reform on the medical oversight model

As chapter 9 argued, embarking on legislative reform in England and Wales on the medical oversight model would be likely to be part of a process of development as the medical and legal establishment engaged more intensively with the right to enabled suicide. Initial legislative reform would be likely to be followed by the introduction of amendments that would tend to widen the categories of potential claimants (9.5). This thesis has argued that a medical oversight model of legislative safeguards as in Oregon or Holland is defensible under the PGC. Such a scheme if introduced in England would mean that defined categories of suicidal claimants with a clear and settled desire to die could take advantage of a non-exceptional procedure. This model of reform removes the need to conflate life-shortening/lethal treatment decisions with enabled suicide, as occurred in *Re B* (treatment refusal) and in Annie Lindsell's case (pain-relieving treatment). However, the current proposal for such a model, the Assisted Dying Bill 2014-15 (2014-15 Bill), is inconsistent

with the reason-based rationale underpinning safeguards against incompetent enabled suicide under the PGC. The restriction in the 2014-15 Bill to applicants who are terminally ill, excluding those experiencing extreme suffering, does not necessarily mean that the reason for suicide is fully evidenced (9.5.4). Having a terminal illness does not necessarily establish that a suicidal PIA has sufficiently weighed his generic interests to the extent necessary to demonstrate that he has a good reason to undergo enabled suicide. It is argued that the failure to engage with the basic generic interests of a patient, aside from those linked to relief from the last stages of dying from a terminal illness, in the 2014-15 Bill, was an endorsement of the disengaged and formalistic approach to assisted suicide in the Oregon model of medical oversight (9.4.2).

A scheme that was compatible with the PGC would retain much of the formality of the 2014-15 Bill (9.5), but it would also seek to involve the designated doctor far more fully in the applicant's reason for suicide (see 9.5.6) and would rely on extreme suffering as its basis (9.5.4). To achieve such an involvement it is argued that the medical oversight procedure would have to require the applicant to evidence the following:

- his condition of extreme suffering that is irremediable (5.4.6; 9.4.3; 9.5.4);
- his competence, by undergoing a 'competence to commit suicide' assessment to screen for depression in terms of passive or self-disregarding suicide (9.5.6; 5.6).

An independent evaluation of this evidence should be conducted by two doctors separately (as under the current Bill; see 9.5.3). However, where an application was advanced within an already established treatment relationship,[8] the independent doctor should adopt a presumption of competence which could only be rebutted by evidence of incapacity. This presumption serves to decrease the administrative burden of the competence test and to encourage an approach that is closer to the Dutch model (see 9.4.3). A doctor who participated in the procedure would have a duty of care that required her to conduct a full competence test; specifically she would have to demonstrate that she was satisfied, as a reasonable doctor, that the applicant had weighed his condition against the continuation of his

[8] I.e. the attending doctor has been involved in the care for the applicant for a substantial period of time prior to his declaration (eg over a year).

life (5.2.3; 9.5.4) and had not merely evidenced his settled and voluntary decision to her. The High Court would have a role in the proposed legislative framework but it would not be a necessary role; rather, it would be one of supporting the medical evaluation. A doctor who is unsure would therefore be able to request that the applicant refer his case to the Court, which could then assess him and issue a declaration on his competence (in a way analogous to its current role in relation to capacity to refuse vital treatment; see 8.4).

It is useful to illustrate the safeguards under the proposed procedure intended to ensure competent suicide (5.4-5.6) using the hypothetical scenario of the transsexual applicant Nathan who is seriously depressed (referred to in chapter 9; see 9.5.6). (It is implicit in the following scenario that the necessary formalities as to suicidal signalling (5.4; 9.5.3) have been observed.) Nathan has recently been diagnosed with terminal cancer with a prognosis of 6 months; he is depressed and becomes suicidal. His given reason for suicide is his anticipation of the extreme suffering caused by pain associated with the dying process (in the scenario in chapter 9 this reason was not advanced since his terminal prognosis was sufficient). However, Nathan's real reason is his irrational fear that palliative pain-relief would undermine his masculine personality in his final moments and he might exhibit behaviour associated with his female personality before gender reassignment. He turns to Roger as his only relation with whom he has maintained contact and who is the beneficiary of his substantial estate. Roger advocates use of the 'PGC-compatible procedure'. After researching the procedure online Roger suggests that Nathan should persuade his usual doctor to vouch for his medical condition and competence, since this removes the need for an independent competence test and is therefore quicker and easier (although there must still be an independent evaluation of his condition and capacity). However, when Nathan approaches his usual doctor she does not want to vouch for him because she considers that he should continue to receive treatment, and she is aware of his serious depression.

Roger therefore advises Nathan to try a practice that supports enabled suicide, which Nathan duly does. At the practice Dr Adams advises Nathan that the 'PGC-compatible procedure' requires extensive evidence of competence which must be evidenced if she is to lawfully participate in it. Dr Adams explains that the first step requires Nathan to demonstrate that his extreme suffering is his reason for suicide and that he has considered pain-relieving treatment and explained his reason for rejecting it. Nathan provides the requested evidence, which is

straightforward in medical terms, but he omits his fear as to reversion to his female personality due to the effects of pain-relieving drugs. Dr Adams explains that the second step requires him to demonstrate that his judgement is not impaired by mental illness or depression and that his suicide is not the product of a lack of self-regard. Dr Adams explains that Nathan cannot provide evidence satisfying this requirement by mere assertion and suggests a psychological evaluation. Nathan rejects this option on the basis that he is afraid that it might reveal his secret fear. Dr Adams suggests that in the absence of an evaluation he should take legal advice on the means of fulfilling this requirement and that Nathan may need a declaration of competence from the High Court. The consultation ends with Dr Adams agreeing to see Nathan again after a fortnight[9] and stating that, if Nathan has obtained the necessary evidence or a declaration, she will refer him to an independent doctor (Dr Black) who will independently review his evidence.

Shortly after his consultation, and while he is considering his next move, Nathan is contacted by his daughter, with whom he was estranged (due to his transexualism). She wants to re-establish relations with her father before he dies and opposes his decision to undergo enabled suicide. His daughter's opposition causes Nathan to consider whether he should delay his suicide, but when Nathan raises these doubts with Roger he puts pressure on Nathan to adhere to his original decision. Nathan therefore decides to go forward with the High Court procedure without delay and contacts Smiths, a solicitors firm. Mr Smith, a senior partner, suggests that, in the absence of a psychological evaluation, family testimony may be viewed as persuasive by the High Court. However, he emphasises to Nathan that the competence test is flexible. Nathan knows that Roger would vouch for him, but Mr Smith doubts that this recommendation is enough. He asks Nathan whether he has close family in addition to Roger and it emerges that the only close family he is in contact with (his daughter) is opposed to his suicide. Mr Smith therefore considers that Nathan may not receive a declaration of competence from the High Court but says that he still has a chance of receiving such a declaration of competence on the basis of Roger's testimony combined with his own. Nathan decides to proceed with his application to the High Court.

[9] This requirement reflects the waiting period in the Oregon Model; see 9.4.2.

At the hearing Judge Hale notes the lack of family testimony other than from Roger and the lack of a psychological evaluation. She therefore finds Nathan's case to be poorly evidenced in terms of his competence, despite his terminally ill condition. She questions Nathan closely about his perception of his condition and as to alternative treatments. She notes that he is very concerned about the effect of late-stage palliative care, but he does not reveal his secret fear and she finds nothing unusual in his concern. She proceeds to question Nathan about his family's attitude. Nathan reluctantly reveals that he has only just re-established contact with his daughter, but emphasises that this has not altered his perception of his condition or his desire to die. After a short period Lady Hale decides that she has not received enough information to make her decision; she suggests that Nathan could satisfy the court if he was to undergo psychological evaluation; she also suggests that Nathan could improve his case if he could provide his daughter's testimony. Nathan weighs his options. He remains opposed to psychological evaluation. He also is not confident that his daughter's testimony would help his case and recalls his feeling of doubt about the process when he discussed the matter with her. Nathan decides to suspend the procedure for a time.

The above scenario illustrates the way in which the deficiencies of the 2014-15 Bill as regards creating a safeguard against depressed suicide (in 9.5.6) would be addressed by the proposed reform. In particular, the procedure should encourage the doctor to assess the applicant's reason for suicide rather than merely relying on it to demonstrate that he has made a decision (as in the 2014-15 Bill, clause 3(3)). It is not suggested that Nathan's subtly distorted reasoning would be revealed by such a procedure but that, in contrast to the procedure proposed by the 2014-15 Bill based on capacity, the evaluation of Nathan's *competence* would find that he was a borderline case. That would be found due to the following factors: his claim did not arise within an established treatment relationship; he was reluctant to provide evidence of his mental state; there was a lack of support from family or intimates. The engagement with Nathan's reason for seeking suicide involved under the proposed procedure, which meant that a psychological evaluation was called for by the officials involved, would have meant that Nathan's serious depression would have been revealed[10] (see 9.5.6).

[10] It is assumed that the attempt would be performed with reasonable skill and be a good faith, committed and sincere attempt.

The requirements of such a procedure are therefore far more onerous to both the applicant and the doctor than the Oregon procedure, despite similar levels of formality. However, the burden imposed is not as great as under the 2014-15 Bill which necessitates a court procedure. Furthermore, the procedure is clearly justifiable as a restriction on the exercise of a right to enabled suicide. If an applicant seeks to die as an expression of his agency, rather than let nature take its course – as a theorised sanctity of life position would prefer – then his reason must be *apparent* in order to provide a safeguard against depressed suicide under the PGC.

10.5 Concluding remarks

Full recognition for the generic right to enabled suicide in English law might at first glance appear to be a hollow achievement from any perspective that respects the unique value of human agency, including the PGC. That is because the unique value of human agency could be taken to mean that evidence of a suicidal agent's reason for suicide should provide an opportunity to *support* him to value his agency in terms of continued life. However, this thesis has considered a number of cases in which a suicidal agent's reason for seeking suicide is founded on a condition which has so undermined his fundamental wellbeing (chapters 5-8) that the general response of supporting him to value his agency, and thus to disregard his suicidal purpose, is not morally permissible (4.4). A commitment to rational agency and to human rights recognises that an agent has a right to *control* his life (chapter 4) which cannot be denied to him on the basis of his physical incapacity or suffering. To interfere with this freedom would *contribute* to the destruction of his agency caused by his suffering and force him into a passive role in relation to it and to his continued existence. This state of impotent suffering is a contradiction of his unique dignity and rights as a rational agent. As discussed, it is therefore contrary to the PGC (2.6).

Thus this thesis has critiqued the near-absolute prohibition combined with certain departures from it represented by the DPP Guidelines, by the doctrine of double effect and the acceptance of refusal of vital treatment. It has rejected the current Assisted Dying Bill as creating arbitrary distinctions between PIAs, on the basis of being both over- and under-inclusive, and therefore as failing to answer to the demands of proportionality due to its lack

of a rational connection to the aim of allowing enabled suicide where the PIA demonstrates competency, as would be accepted under the PGC. The Bill is under-inclusive since it excludes those who exhibit extreme suffering, but over-inclusive since its safeguards against involuntary killing are inadequate (9.5). This chapter has therefore proposed a legislative change allowing for a procedure that would be PGC-compatible due to its ability to answer to a settled, competent decision to seek enabled suicide, and to engage reasonably fully with that decision in order to ascertain that it is competent. The rejection of the sanctity of life position in this thesis in favour of a PGC-compatible one is intended to rest on a superior conception of human dignity foundational to human rights.

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